CLINICIANS' DESCRIPTIONS OF THEIR EXPERIENCES AS SEX OFFENDER THERAPISTS

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TABLE OF CONTENTS

Page

CHAPTER I

Introduction

The purpose of this study is to explore the experience of sex offender therapists. It is to have them tell what is going on in sex offender treatment. This study is about how being a therapist who works with sex offenders is an unusual undertaking. The process of therapy itself is already not a typical social interaction. Sex is a very private issue for most people. The idea of talking with another person about issues of his sexuality adds a definite confound to the situation. Added to that, the therapist engages the sex offender as a non-participant observer in the sex offender's sexual behavior. The issues addressed in sex offender treatment are also not limited to the already difficult domain of normal sexuality but focus almost exclusively on deviance. This puts the sex offender therapists in a complicated position. In their role as treatment providers for sex offenders, they are basically functioning as social control agents. They are in the unique position of those who both decide (to some extent) what sexually deviant is for others, and attempt to influence others to be non-deviant. Where does this special knowledge and authority come from? How do clinicians feel about sex offender? What effect does this work have on the clinician?

This study attempts to answer this and other questions. Sex offender therapists are no more immune from the general social influences that other people's ideas about sexuality come from. What is the source of the definition of sexual deviancy for sex

offender therapists? Blumer (1969) stated that "meanings for a person arise fundamentally out of the way things are defined by others with whom she interacts" (p. 49). Sex offender therapists draw their references for sexual propriety from the same social norms that the general public does. There is no unique training ground for sex offender therapists that is different from that in which general sexual norms are derived. The most interesting aspect of this revelation is the fact that sex offender therapists do not inherently possess any better a gage to determine appropriate sexual behavior than anyone else does.

It is also a salient matter that people's sexual norms are a product of their primary social environment (Gagnon & Simon, 1973). This is especially interesting given that a unique source of influence on the determination of a sex offender therapist's definition of what is sexually appropriate is the sex offender clientele that they primarily interact with. It is fairly obvious that sex offenders themselves hold different sexual norms than the general public. That being the case, it is at least curious that sex offender therapists are the people who get to decide for sex offenders what is and what is not sexually appropriate.

What is the formula for addressing sexual deviancy? Who addresses it? As a former sex offender therapist myself, I have not experienced sexual assault personally. Those who have experienced sexual assault can attempt to relate to the rest of us what it was like. They can attempt to tell us what they needed to do, to see, to feel. Those who do relate their accounts do not tell these accounts unaffected by the experience themselves. There are parts of the experience that we who have not experienced sexual assault can never truly understand. Those of us who have not been there can not know.

The sex offender therapist hears the account of the man who inflicts the trauma. She processes the experience with the offender. She meets with him some time after the offense in an attempt to do some kind of amelioration. The offender himself of course, can not give us the victim's view. He doesn't or perhaps isn't capable of seeing his victim's view. If he were, he probably wouldn't have done what he did in the first place. The therapist is not the person who did the offense nor had it done to him. He doesn't share the offender's history, or necessarily the victim's. The therapist is the person that attempts to change the behavior of the offender, and in the process, even prevent future victimization. He has to attempt to make sense of sexual deviancy from the other side of the looking glass, the side where it is difficult to make sense of it.

The therapist stands in for all the rest of us. We grasp, and try to make sense of…the what…the why…? Although I was very interested in talking with therapists about sex offenders and sexual deviancy itself, that is not what they were primarily interested in talking about. An early discovery in the course of this project was the realization that sex offender therapists very much wanted to talk about their work. They wanted to talk about how the work affected them, how sex offender treatment is different from therapy in general, and finally there was some discussion of sexual deviancy and sex offenders themselves.

Those who work with sex offenders must contend with some difficult social issues. Between 1988 and 1990, the number of sex offenders in U.S. prisons grew by 48% (Marques, Nelson, West & Day, 1994). In some jurisdictions, sex offenders are one-third of the prison population (Polizzi, MacKenzie & Hickman, 1999). The concurrent increase in numbers of reported sex offenses and the increasing costs of incarceration

magnify the necessity for understanding and successfully treating sexual offenders. The results of outcome studies assessing the effectiveness of sex offender treatment programs are often contradictory, ranging from positive effects (Marques *et al.,* 1994; Valient & Antonowicz, 1992), through no effect (Lab, Shields & Schondel, 1993; Pithers, 1994) to negative effects (Furby, Weinrott & Blackshaw, 1989).

Another problematic issue for sex offender therapists is the question does sex offender treatment work? The answer depends upon who you ask (Furby *et al*., 1989 or Kersting, 2003), when you ask (80s, 90s or today), or what you measure (recidivism or dynamic factors). The only certainty that can be drawn from attempts to answer the question "Does sex offender treatment work?" is that there is little consistency drawn from meta-analysis and literature reviews with regard to the effectiveness of sex offender treatment (Polizzi *et al*., 1999).

One consistent finding in outcome studies is that cognitive behavioral sex offender treatment programs are more effective than other forms, such as systemic or behavioral treatment programs (Hanson, Gordon, Harris, Marques, Murphy, Quinsey & Seto, 2002; Kear-Colwell & Pollock, 1997; Polizzi *et al*., 1999). One explanation for this finding relates to the multidimensional nature of cognitive behavioral treatments. The causal factors in the genesis of sexual offending behavior are many and varied. In the absence of a sound theoretically based approach to treating sex offenders, the multi-factor approach utilized in cognitive behavioral treatment programs represents an attempt to broadly address the varied treatment needs of this population (Anechiarico, 1998; Ward, Hudson & Marshall, 1995). These programs generally include relapse prevention education, empathy development, social skills and assertiveness training, and arousal

reconditioning (O'Connell, Leberg & Donaldson, 1990). In the absence of an integrating theory to drive the development and delivery of sex offender treatment, a cognitive behavioral approach represents perhaps the broadest response, much like an all encompassing blanket treatment approach to a marginally understood problem.

Many reasons have been cited regarding the inconsistencies in sex offender treatment outcome studies. Since recidivism rates even for non-treated sex offenders are low it is difficult to assess a significant treatment effect for treated verses non-treated sex offenders (Kersting, 2003). Relying upon recidivism as a measure of the effectiveness of sex offender treatment is also problematic. According to Hanson and Thornton (2000), observed recidivism substantially underestimates actual recidivism. The use of a single static measure, such as recidivism, to assess the effect of a multi-factor treatment on a multi-factor problem is extremely imprecise (Dwyer, 1997; Marques *et al*., 1994). Methodological flaws in the study of sex offender treatment programs are also regularly cited as a major weakness of many reported outcomes (Furby *et al*., 1989; Marques, 1999; McConaghy, 1999).

Statement of the Problem

Sex Offenders are different from most other clients a therapist is likely to see in general practice. Most people approach counseling under their own volition. Most sex offenders do not go into treatment voluntarily (Salter, 1988). The nature of treatment for sex offenders is very different from that found in a more typical client/therapist relationship. The therapist who treats sex offenders must have some specific and uncommon qualities to do an effective job treating sex offenders. Traditional training for

therapists focuses on attending to the needs of the individual client. Sex offender therapists must be willing to balance the needs for safety of victims and the community against the individual therapeutic needs of the offender (O'Connell, *et al*., 1990).

The majority of people (including therapists), react with some combination of shock, horror and incomprehension when considering the issue and details of sexual abuse. Sex offender therapists must address these personal reactions in a manner that does not inhibit the delivery of treatment. The clinical literature has little to say regarding how therapists manage their own emotional reaction to sex offenders (Polsom & McCullom, 1995). This lack of data inspires interesting research questions regarding the experience of sex offender therapists confronted with these difficult issues. How does the therapist balance his or her professional commitment to both the community and the offender? What effect does exposure to objectionable sexually deviant content have on the therapists own concepts about sexuality? Consistent with clinical findings from research with general practice clients, self-reports of treated sex offenders indicate that therapists' caring attitudes and behavior were crucial to the offenders' perception of successful therapeutic outcomes (Kear-Colwell & Pollock, 1997). How is the therapist able to develop and retain a therapeutic professional regard for the offender? How do they manage their negative reactions to the offender while engaging therapeutically with him? The intent of this exploratory study is to shed some light on these and other questions regarding the experience of sex offender therapists.

Symbolic Interaction

Qualitative research allows researchers to share in the understandings and perceptions of others (Patton, 2002). It also allows exploration of how people structure

and give meaning to their experiences. Qualitative techniques examine how people make sense of themselves and others. The analysis of qualitative data enables the researcher to discuss in detail the various processes people use to create and maintain their social realities (Crotty, 1998). A symbolic interactionist approach to qualitative research stresses that human interactions form the central source of data. Participants' perspectives are key issues in the formulation of a theory of symbolic interaction (Berg, 1998). To understand a phenomenon as complex as sex offender treatment, I attempt to explore the definitions and meanings of sexual deviancy that sex offender therapists employ in their work with sex offenders, and the processes by which these meanings have been created.

Research, from a symbolic interactionist perspective, focuses on understanding how individuals take and make meaning in interaction with others (Marshall & Rossman, 1995). Sex offender treatment is an especially elaborate form of social interaction. Human behavior is an ongoing and negotiated interpretation of objects, events and situations (Bogdan & Biklen, 1992). Sex offender therapists bring meaning about sexual deviancy to their work before even beginning work with sex offenders. These meanings arise through social processes that sex offender therapists as well as everyone else in a society are immersed in. A symbolic interactionist perspective would attempt to understand how these meanings about sexual deviancy would change through direct interactions with sex offenders. To facilitate a better understanding of these processes, I attempt to develop a sufficient appreciation for the processes of meaning making among clinicians working with this population. My expectation is that this information facilitates a better understanding of the phenomenon of sex offender treatment.

Purpose of the Study

The purpose of this qualitative study is to generate an improved understanding of sex offender treatment that is grounded in the experience of sex offender therapists by exploring therapist descriptions of those experiences. The overall aim in this study is to explore what the experience of being a sex offender therapist is like. A specific emphasis is on what are the effects upon sex offender therapists working with sex offenders. From these identified experiences I hope to contribute an improved understanding of the therapist qualities guiding the practice of sex offender treatment.

Delimitations and Limitations

The subject of this study was the experience of twelve sex offender therapists from the Midwest who have worked professionally as sex offender therapists. The range of experience was between 3 and 30 years in order to draw from early and seasoned descriptions of working with sex offenders. The central phenomenon of interest was descriptions of the experience of working with sex offenders as a sex offender therapist. Another phenomenon of interest was the manner in which the therapists' theory of sexual deviancy guides treatment provision.

The aim of this study was to use qualitative methods to describe and explain the experience of sex offender therapists as accurately and completely as possible. The constructivist inquiry I undertook presupposes different criteria for reliability and validity than those inherited from traditional social sciences research. Lincoln and Guba (1986) emphasize that naturalistic inquiry should be judged instead by dependability (of the processes for collection and analysis of data), and authenticity (consciousness of ones'

own perspective and appreciation for the perspective of participants). In the constructivist view, the social world is constructed from human understandings and explanations (Patton, 2002). In this study, my focus was upon approaching a deep understanding of the experiences of the sex offender therapists participating rather than in discovering causal explanations or inferring empirical generalizations.

Definition of Terms

1. Sex Offender Therapist: a mental health therapist with a minimum of a Masters degree in a mental health related field who has worked primarily or exclusively with sex offenders for a period of no less than three years.
2. Sex Offender: for the purpose of this study this term referred primarily to adult males who had been convicted of rape or sexual assaults of children (some but very few of the participants also made some references to their work with adult males who had been convicted of rape or sexual assault of adults).
3. Community Treatment: court ordered sex offender treatment programs that are based in the community (with some sex offenders convicted and some complying in order to receive deferred or reduced convictions).
4. Residential Treatment: prison based sex offender treatment programs for convicted sex offenders.
5. Arousal Re-conditioning: behavioral treatment procedures designed to alter deviant sexual arousal.
6. Re-enactment: a sex offender treatment procedure in which the offender re-creates his crime portraying both his and his victims actions.

7. De-briefing: the process in which the sex offender therapist meets with treatment staff following a difficult treatment procedure in order to deal with the effect that the procedure might have had on them personally.

CHAPTER II

Review of Relevant Literature

A symbolic interactionist explanation of deviancy asserts that deviancy is defined socially (Becker, 1963) and that sexual deviancy is a social construction. Symbolic interaction emphasizes that people are influenced by the sexual meanings that they learn from society. Gagnon and Simon (1973) suggest that a "script" comprised of a definition of the situation regulates sexual activity, such as, who is an appropriate partner and what are appropriate behaviors. Sexual identity and sexual preferences are regulated by this script which is constructed through social interactions (Carr, 1999). A historical approach emphasizes that societal messages about sex have changed over time, including messages about what is and is not considered sexual deviancy (Longmore, 1998). Many sexual behaviors that have been considered deviant or perverted in the past are not considered so today.

Historical Perspective

A symbolic interactionist emphasis upon the creation of the meaning of sexual deviancy as a social process will be aided by an attempt to understand these processes in a historical as well as a social perspective. As Blumer (1969) states, "It is the social process in group life that creates and upholds the rules, not the rules that create and uphold group life." In colonial America, the notion of romantic love and intimacy serving

as the foundation for mate selection was considered deviant (Foucault, 1978; Higginson, 1999; Lantz, Keyes & Shultz 1975). During this same period, the utility of sex was limited to procreation. In the mid 20th century, sex came to be seen also as a means for enhancing intimacy. Later still, an alternative cultural message emerged in which sex became a legitimate means to individual pleasure (D'Emilio & Freedman, 1988). The belief that masturbation caused physical disease and insanity was upheld as a medical truth as late as 1917 (Weeks, 1981). Freud upheld this medical explanation as one of the centerpieces in his theory of the sexual causation of neurosis (Leahey, 1992; Szasz, 1983). Today, masturbation is exalted as therapeutic and is a scientific centerpiece of sex therapy (Masters & Johnson 1966). Even the once dreaded crime/disease of homosexuality has lost its status as either crime or disease. While many so called Blue Laws prohibiting homosexual behavior still exist, they are generally unenforced. Concurrently, the DSM also no longer lists homosexuality as a mental disorder (Leahey, 1992).

Clearly there is little about our current sexual attitudes and practices that can be considered sacred and unchangeable. They have been subject to much change in the past and will most likely continue to change. While some of these changes have generally been direct reversals, i.e. coitus interruptous was a sin equated with murder in the 18th century but today it is accepted as healthy family planning (Flandrin, 1976), other similar changes have been more like gradual retreats from original rationales for prohibition in order to reconstruct the rationales, but retain the prohibition.

The taboo against incest and pedophilia has continued throughout history (with some rare exceptions) and across cultures (Soothill, 1980; Twitchell, 1987). But the

rationale behind this prohibition has gone through multiple transformations. These transformations have coincided with other social changes that appear to be related directly to the changing rationales for these behaviors.

Theories about the origins of incest taboos are primarily based on economic rationales. The real harm was considered to be the disadvantage of not out-breeding to other clans to increase social cohesion with those other families and clans (Justice & Justice, 1979; Twitchell, 1987). A related economic rationale addresses the property status of children as trade commodities; incest taboos insured the trade value of progeny (Serrano & Gunzburger, 1983). These economic conditions no longer exist but still the prohibitions against incest and adult-child sex remain.

Biological explanations posit that incest increases the possibility of genetic deformities and that this primitive awareness leads to a natural aversion (Twitchell, 1987). Paradoxically, incest taboos exist even in societies that have no knowledge of reproductive causality (Twitchell, 1987). Furthermore, except under rare, multigenerational inbreeding exceptions, biological harm doesn't occur. Experts in animal husbandry (such as race horse and dog breeding specialists) have long been aware that the advantageous results of genetic enhancements are actually the product of inbreeding, and that abnormalities are quite rare (Justice & Justice, 1979). Early 20th century incest laws have been rewritten to accommodate this new biological understanding of genetics. Laws that were based upon the prevention of genetic defects from incest now stress "the protection of family solidarity" (p. 276). The offensive behavior in question also changed from a focus on intercourse, to a focus on any act

designed to stimulate a child sexually or to use a child for sexual stimulation (Justice & Justice, 1979).

This shift in focus represented a move away from biological rationales prohibiting incest toward a more socio-biological explanation. These explanations prohibit incest because it undermines family cohesion. Sexual activity among family members is said to stir up passions and jealousies that make harmonious family life impossible and to confuse familial roles and duties (Davies, 1979; Justice & Justice, 1979). Based upon the economics of the family unit, incest was inefficient (Serrano & Gunzburger, 1983). All societies expect sexual activity to occur within marriage: a major social function of marriage is to regulate access to sexual gratification. Other sexual activities are evaluated in terms of whether they are functional or dysfunctional toward the maintenance of the family unit. In the socio-biological rationale, incest dramatically disorganizes the family unit (DeLamater, 1981). This rationale for the incest taboo was especially relevant through the 19th and early 20th century when the self-contained family was the primary economic unit. Even overly sentimental attachments within the family were suspected of undermining order, much as work-place romances are viewed today (Flandrin, 1976).

The strongest current justification for the provision of sex offender treatment is the protection of society, especially children, from the detrimental effects of sexual abuse. The 20th century is marked by an exceptional concern with children and their development. Children have come to be viewed as pure and in need of special care to preserve that purity (Reese & Katovich, 1989). The changing attitude toward children that now sees them as innocent and struggling to be formed manifested itself as

legislation in the Incest Act of 1908 (Twitchell, 1987). The intensified emotional investment in children was coupled with a fear of sexual corruption. The notion of victim of pornography shifted from young women to children around this same time (Weeks, 1981). The rhetoric, which fueled the passage of the Comstock anti-obscenity laws in 1873, was to "protect the purity and innocence of youth against the wiles and intrigue of the wicked" (McGarry, 2000). During this time, children were viewed as pure. Sexuality was viewed as so potentially corrupt that even medical texts that addressed reproduction physiology were successfully prosecuted as obscenity (Weeks, 1981). More recently, the 1970 report of the Commission on Obscenity and Pornography "found no evidence that exposure to explicit sexual material plays any significant role in the causation of criminal behavior among youth or adults" (p. 17). The Commission still recommended regulating such material for minors (Shattuck, 1996). It is also no accident that Anita Bryant's 1976 anti-gay campaign was called "Save Our Children, Inc" (Weeks, 1981). This anti-gay rights reform movement used the specter of child sex abuse and recruitment to bolster an apparently weakening social condemnation of homosexuality.

A curious indicator of the importance of protecting children from sexuality is that there is no set of sexual behaviors that is considered appropriate for this stage of life, except of course, a lack of sexual behavior (Reiss, 1967). The view of childhood asexuality ignores much of the existing evidence to the contrary. The shock for adults of Freud's discoveries of childhood sexuality was not that children might be involved in sexual activity, but that this activity was not confined to a few evil children and was in fact an important precursor to healthy development (Rubin, 1984). American scientists themselves have been unwilling to study the sexuality of children. A 1995 review of

research on sexuality in the United States is notable for the fact that it makes no mention of childhood sexuality (Francoeur, Koch & Weis, 1998). Even the popular book *Everything You Always Wanted to Know About Sex, but Were Afraid to Ask* makes no mention of either childhood sexuality or incest (Reuben, 1969).

Paradoxically, the growing awareness of the importance of childhood that produced increased concern for protecting children also produced increased efforts to squelch childhood sexuality. Although there are exceptions, the greater conscious concern by adults with the processes by which children learn about sexuality has manifested as measures to insure that children do not learn about sexuality. Of course, this agenda has not been especially successful. A primary source of the impetus to protect children from the destructive potential of sexuality is the developmental notion that early life events can have lasting and defining influences later in life. Much of the reasoning for protecting children from adult-child sex attests to these long lasting detrimental effects attributed to childhood sexual trauma. These effects include PTSD symptoms (Ruggiero, McLeer & Dixon, 2000; Vanderbilt, 1992), a broad range of psychosocial disorders (Butler, 1985; Shearer & Herbert, 1987; Travis & Titus, 1996) adult sexual dysfunction (Butler, 1985; Salter, 1988) and a host of other psychological disorders (Ruggiero *et al*., 2000; Steele & Alexander, 1981).

With only a few exceptions in western culture, prior to the 20th century, sex was largely regarded as a demon that needed to be contained, as a powerful drive or force that required extensive social structures to assure that its destructive potential did not erode society and its institutions (Giddens, 1992; Plummer, 1975; Rubin, 1984; Shattuck, 1996). Extensive rules, laws, and sanctions were created to restrain sexuality to its sole

beneficial purpose, that of procreation (DeLamater, 1987; Kirk, 1977). Kinsey (1948) has calculated that if sex laws were actually enforced, 95% of the male population of the United States would be in prison. Up to the 19th century, American society's response to sexual transgressions depended upon whether or not the person repented and thereby agreed to come back into the social flock and turn away from evil (D'Emilio & Freedman, 1988). Persons willing to display some social form of repentance were often granted grace and forgiveness and returned to their former social status. Persons who refused to turn away from deviance were punished with the harshest of penalties, sometimes including death (McGarry, 2000). These were crimes against the natural social order and considered injuries to the whole community (Davies, 1982). As a more tangible concept of individualism formed in the 20th century, the onus of responsibility for sexual deviation rested more and more within the individual. An acceptance of sexual deviancy as a disease within the individual provides the medical field with a justification for curing the disorder.

Labeling Theory

Labeling theory as an approach to the study of deviancy (including sexual deviancy) emerged in the late 1960's. This approach is consistent with symbolic interactionism in that it focuses on the role of social interactions rather than individual nature in the phenomenon of deviance. In this view, social groups create deviance by making the rules whose infraction constitute deviance and then applying those rules to particular people and labeling them as deviant (Becker, 1963). Since social groups create rules, they also create deviance. If there were no rules there would be no deviancy. This

theory directs attention to rule-makers and enforcers as much as to rule-breakers. It directs attention to the values, beliefs and attitudes of labelers. Labeling theory has problems explaining the issue of sexual deviancy. One problem is the almost universal nature of the taboo against incest and adult-child sex (Soothill, 1980; Twitchell, 1987). Also there is exorbitant support, not to mention public opinion that suggests that sexual deviancy is driven by abnormal psychology (Gove, 1975).

The major premise of Labeling theory is that deviance is not inherent in the act itself, but arises from the response of others to the act. Becker (1963) asserts that labeling someone as deviant actually serves to amplify that person's deviance. He offers the term Master Status to describe how a person labeled deviant, such as a sex offender, is from then on seen primarily through that lens only. Everything he does gets interpreted foremost as a characteristic of the label. As the individual becomes more stigmatized he is also excluded from conventional associations and contacts. This limits him even more fully from breaking out of the deviant role.

In Rosenhan's (1975) classic study, he describes how a group of graduate students got themselves admitted to a mental hospital by reporting that they had heard auditory hallucinations on a single occasion. After being admitted they resumed completely normal behavior while in the hospital. Examination of hospital records kept by staff on these students revealed that all of their subsequent "normal" behavior was viewed by professional staff as consistent with the initial label of mental illness that they were admitted under. Rosenhan (1975) states that eventually, patients accept their diagnosis with all its surplus meanings and expectations, and then behave accordingly. Szasz (1974) refers to this phenomenon as type-casting. He states that not only are the

behaviors of type-casted individuals interpreted in a way consistent with the role they are assigned, but that they also are reinforced and therefore individuals begin to act consistent with the role as well. The labeled individual begins to employ her role as a form of adjustment to the situation she is now in as a result of being labeled. Scheff (1984) asserts that persons labeled as deviant are even punished if they attempt to return to conventional roles. The implication of this last proposition is especially sinister as it applies to sex offenders. If the sex offender accepts his "master status" as a sex offender, then complying with the expectations of the role could include continuing to engage in sexual deviancy.

The needs for diagnosis and remediation of behavioral and emotional problems are enormous especially in relation to sex offenders. But rather than acknowledge that science is just beginning to understand these issues, we continually rely on labels as if in the label we have captured the essence of understanding. The truth is well known that many diagnostic labels are not reliable and often not even useful, yet they continue to be used ardently (Alexander, 1997). Labeling clearly serves a purpose other than stating a truth. There is a social, cultural, and interpersonal status quo whose existence is only felt when it is violated (Scheff, 1975). Labels are employed to help us identify, separate and deal with those who violate our social norms.

Sexual Deviancy as Mental Disorder

A plethora of scientific explanations emerged with the rise of individualism which explained incest and pedophilia as a pathology that resided within the individual. Science began to accept (and promote) the premise that there is something inherently deviant

about adult-child sex that breaks social rules, and that there is some characteristic of the person that makes it inevitable that he will act deviantly (Becker, 1963). Many scientific explanations have arisen including genetic disorders, (Berliner & Meinecke, 1981) underdeveloped genitals, (Costler & Wiley, 1937) re-living their own sexual abuse, (Salter, 1988; Briggs, 1995) interpersonal impairment, (Laws, 1989; Ward, Hudson & Keenan, 2000) and co-morbid psychiatric impairments (Raymond, Coleman, Ohlerking, Christenson & Miner, 1999). These varied explanations of human nature have contributed much to the problem of sorting out the natural and the cultural.

The view that emerged as a means to place responsibility upon the individual has evolved perhaps beyond its original purpose. Medical and psychological science provides both a medical explanation and a moral justification for sexually deviant behavior (Alexander, 1997; Szasz, 1974). If sexually deviant acts are symptoms of a disorder then the pedophile is sick and therefore not responsible for his behavior. Identifying sexual deviance as a disease also provides the medical field with a justification for "curing" the disorder, rather than having to deal with the moral implications of "controlling" behavior. The onus still remains upon science to define the nature of the disorder of sexual deviancy. Many plausible explanations have arisen and contributed directly to the provision of treatment.

Cognitive-behavioral treatment programs incorporate a relapse prevention framework. Although this approach was originally developed for the treatment of addictive behaviors, it has been adopted widely for use with sex offenders (Laws, 1989). This multi-component approach helps sex offenders to identify high risk situations or precursors which could contribute to their acting out on their sexual deviant thoughts and

fantasies. Relapse prevention approaches educate offenders on how to effectively intervene upon their own sexually deviant cycle of behavior. The objective of treatment is to develop and employ coping responses to these high risk situations (Marques *et al*., 1994).

Empathy enhancement treatment entails experiential exercises designed to help the offender gain an understanding of the destructive effects of sexual abuse on his victim. It is hoped that the offender will learn to take the perspective of the victim and that this awareness would inhibit the sexually abusive act (Pithers, 1994). Much emphasis is placed on the concept of empathy in relation to sex offenders. It is often intuitively observed that sex offenders lack the capacity for empathy (Salter, 1988). Research has revealed contradictory results about whether sex offenders experience empathy deficits, a specific lack of empathy just toward their victims, or have no empathy deficit at all (Fisher & Beech, 1999). 93% of sex offender treatment providers reveal that their treatment programs include an empathy development component (Roys, 1997).

Psychodynamic explanations of sexual deviancy posit that the individual has become fixated at an early stage of psychosexual development, or has regressed back to this stage (Marmor, 1971). The choice of deviant pattern is directly related to complex personal historical determinants. In the case of sexual offenders, these determinants often include the offenders own sexual victimization earlier in life (Briggs, 1995). These determinants have to be uprooted through extensive psychodynamic evaluation.

The social inadequacy model also represents a common facet of sex offender treatment programs. This model describes the sex offender as an individual who has difficulty achieving normal or satisfactory sexual relations with a mature or appropriate

partner. Deviant sexual behaviors represent alternative ways of attempting to achieve sexual gratification (Marmor, 1971). Sex offenders consistently score significantly lower on measures of social competence (Fisher & Beech, 1999). Dwyer (1997) reports that increased scores on post-treatment social skills assessments correlate with reduced recidivism.

Another common treatment approach is the arousal reconditioning model. This treatment technique is a borrowed method originally developed for the re-conditioning of homosexuals in past decades. This explanation for sexual deviancy asserts that the stimuli which produce sexual arousal are repeatedly reinforced through sexual gratification, such as orgasm. Inappropriate stimuli (such as images of children) are paired with the reinforcement of sexual gratification. These reinforcements either occur through early sexual experiences with children or masturbation to fantasies of children. Treatment consists of re-conditioning the flawed arousal pattern. This includes pairing the former inappropriate stimuli with an aversive experience (such as odor or mental image). Re-conditioning also includes pairing the positive reinforcement of sexual gratification with appropriate stimuli such as mature appropriate partners (Berliner & Meinecke, 1981). The arousal model is also cited as a basis for the use of anti-androgenic medications as a treatment procedure to reduce or eliminate sexual arousal. Some sex offenders who admitted to not being able to stop their sexual deviant behaviors reported that with medication they were able to stop (Berliner & Meinecke, 1981).

These multiple explanations for sexual deviancy have informed multiple and varied approaches to sex offender treatment. Therapists working with this population often encounter contradictions within these varied models that can prove problematic in the attempts to deliver a coherent and structured treatment regimen. Other contradictions also complicate the provision of a coherent and effective treatment for sexual deviancy. Roundy and Horton (1990) discuss four practical problems the clinician must address in working with sex offenders.

1. Who is the client? Is it the offender? The victim? The community? Each has a different set of expectations. A traditional therapist/client alliance is severely compromised by fundamental issues of confidentiality and consent for treatment. How does the clinician successfully navigate these issues?

2. Does treatment help? Answers to this question are ambiguous at best (Kersting, 2003). No generic cure currently exists. Treatment approaches consistently apply a homogenous approach to a very heterogeneous group that includes rapists, pedophiles and exhibitionists as if the dynamics of each behavior were similar.

3. Is the offender interested in treatment? Typically the answer is no. Sex offender treatment is almost universally compulsory. There is also a strong impetus for sex offenders to be non-cooperative with clinicians, especially in regards to full disclosure of sexual deviant behavior.

4. What are the effects of therapist bias on treatment? The clinician cannot help but enter the therapeutic relationship with his or her own biases and personal issues regarding sexuality and sexual deviancy. Aside from personal bias, clinicians in this field must

also weather social biases against working with sex offenders. Many sex offender therapists experience criticism or ostracism from their community (Bernard, Fuller, Robbins & Shaw, 1989). Sex offender therapists can also experience a lack of support from their professional community, especially from those that promote victim treatment and offender punishment (Polson & McCullom, 1995).

Working with sex offenders can provoke strong emotional reactions of anger and disgust which can both negatively effect the therapist (Briere, 1989), and the effective provision of treatment (Reddon, Payne & Starzyk, 1999). Therapists who choose to treat sex offenders must be committed to treatment as a critical response to the problem of sexual abuse.

Vicarious Traumatization

Any study attempting to address the dynamics of sex offender treatment from the therapist's perspective must explore both what effect working with sex offenders has on the therapist, and how that effect might then manifest in the treatment process. Therapists in general, and sex offender therapists in particular, routinely are exposed to distressing content. It was not until 1980 that the American Psychological Association first formally addressed the idea of concern about the problem of therapist distress (Kilberg, 1986). These initial concerns attended primarily to stress, burnout and alcoholism as factors contributing to the impairment of effective service delivery. From preliminary studies, greater attention continues to emerge concerning the issue of therapist's well-being as well as concern for clients.

Recent authors have identified a glaring lack of attention in social sciences research as to the effect that doing therapy has on the therapist (Dalenberg, 2000; MacCormack, 2001). Millon, Millon and Antoni (1986) suggest that this reticence is due to an over emphasis on self-reliance and professional autonomy among psychologists. It seems ironic that the profession of psychology has only recently begun to address the potential mental health problems of its own practitioners. It is probably no coincidence that the professions emerging willingness at self examination coincides with gains in the last two decades in understanding the effects of trauma in general.

The concept of Vicarious Traumatization was first described by McCann and Pearlman (1990) to explain the effect of the work on therapists who work with trauma victims. Vicarious traumatization refers to "profound psychological effects…that can be disruptive and painful for the helper and persist for months or years after work with traumatized persons" (p. 136). McCann, Sakheim and Abrahamson (1988) have presented a Costructivist Self-Development Theory that is interactionist in nature, which outlines the development of vicarious traumatization. In this theory, schemas about the self and the world are vulnerable to disruption as a result of exposure to trauma. Traumatic experiences are most likely to affect schemas related to each individuals most central need areas. Adaptation to trauma is the result of an interaction between life experiences and the developing self. These developmental issues include identity, psychological needs, schemas about self and the world, and ego resources. When the environment presents information that cannot be assimilated into existing schemas, accommodation must occur (Piaget & Inhelder, 1969). New or modified schemas are

developed. When trauma presents a challenge to the individuals schemas, painful identity, emotional and interpersonal changes occur (McCann and Pearlman, 1992).

According to Constructivist Self-Development Theory, therapist's vicarious traumatization is an adaptive response to traumatic content disclosed by clients (Pearlman & Saakvitne, 1995). Therapists develop adaptations as self protection against the emotionally traumatic experience of exposure to another's traumatic content (Farber, 1983). These changes are cumulative and pervasive and can affect every area of the counselor's life. They are also potentially permanent as they are regularly reinforced by each subsequent exposure to recurring traumatic content disclosures inevitable in the profession (Trippany, White-Kress, Wilcoxen and Allen, 2004).

Seven schemata have been identified which are especially susceptible to trauma-induced alteration. These include (1) the individual's personal frame of reference about self and others in the world; (2) safety; (3) dependency and trust; (4) power; (5) esteem; (6) independence; and (7) intimacy (Curtois, 1993; McCann and Pearlman 1992). McCann and Pearlman (1990) also argue that these cognitive shifts that result from exposure to traumatic client material may create a general emotional distress in therapists, including heightened anger, guilt, fear, grief, shame and inability to contain intense emotions. It is very likely that these cognitive shifts may interfere with effective functioning in the therapeutic role (Herman, 1997).

Early exploration into therapist's distress related to work addressed the concept of burnout. According to Maslach (1986), burnout is a syndrome of emotional exhaustion, depersonalization, depletion and deterioration resulting from excessive work demands. It is accompanied by a sense of reduced personal accomplishment that occurs among

individuals who work with people in some capacity. When the emotional stresses inherent in providing social and psychological help are not acknowledged and dealt with, they often lead to burnout (Pine and Aaronson, 1981). Moreover, burnout is greater when the nature of the client contact is especially upsetting, frustrating or difficult (Maslach, 1986).

Burnout is differentiated from vicarious traumatization in that burnout focuses more on the effects of working with difficult clients. Vicarious traumatization, on the other hand focuses more on the effect that exposure to the clients traumatic content has on the therapist (McCann and Pearlman, 1990).

Vicarious traumatization overlaps considerably with the concept of secondary traumatic stress (also called compassion fatigue). According to Charles Figley (1988) secondary traumatic stress is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 638). Figley (2002) cited the provision in the DSM diagnosis of PTSD that qualifies bearing the distress of others who are traumatized" as criteria for secondary traumatization. The symptoms of secondary traumatic stress mimic those of post traumatic stress disorder but at a sub-threshold level. In Figley's model, the therapist's potential for empathic connection to the client renders her more vulnerable to the effects of secondary traumatic stress.

Both vicarious traumatization and secondary traumatic stress describe therapists' reactions to exposure to client disclosures of traumatic content. Both describe these reactions as parallel to sub-clinical PTSD symptoms, including avoidance, intrusive

thoughts and images, and arousal symptoms (Amen, 2002). But, Pearlman and Saakvitne (1995) assert that the vicarious traumatization concept better accounts for the long term disruptions in therapist's cognitive schemas such as worldview, identity and spiritual issues.

Vicarious traumatization has been conceptualized as a counter-transference reaction by Pearlman and Saakvitne (1995). They proceed to define counter-transference very globally as "our reactions to our clients and their material" (p. 23). These reactions may be used to direct therapeutic choices. They can also have seriously negative consequences to the therapeutic process (Dalenberg, 2000). Vicarious traumatization is conceptualized as specifically arising from the therapist's exposure to the client's traumatic material. Counter-transference can occur outside the context of any traumatic content. Vicarious traumatization is a type of counter-transference but it is a specific reaction to the client's disclosure of traumatic material.

It is evident that there are many similarities among the varied terms used to describe the impact of exposure to traumatic content upon the therapist. It appears that these are very similar terms for the description of the same basic phenomenon to some extent. Adding to the confusion, these terms are also often used interchangeably in the literature addressing this phenomenon (Stamm, 1997). This study will proceed with an emphasis on the concept of vicarious traumatization because it is based on a constructivist personality theory which is consistent with the theoretical approach utilized in this study. Vicarious traumatization will also be the preferred concept because of its emphasis on the role of meaning and adaptation rather than focusing primarily upon a set of symptoms.

Empirical Support for Vicarious Traumatization

Studies addressing the effects of exposure to other peoples traumatic experiences has been completed in many varied professional domains, including: policeman, fireman and emergency service personnel (Beehr, Johnson & Nieva, 1995; Moran & Britton, 1994; Violanti, & Aron, 1993; and Wagner, Heinrichs & Ehlert, 1998); physicians and nurses (Lyon, 1993); and corrections workers (Janik, 1995). These studies have found the workers responses are similar to those of trauma survivors.

Black and Weinreich (2000) in a mixed methods study examined a team of 10 counselors that responded to a community terrorist bombing in Northern Ireland in which 29 people were killed. A measure used was the Identity Structure Analysis (ISA). The ISA explores the identity of individuals in relation to their social world. When compared with a control group, the trauma therapists revealed a higher extent of vulnerable identities (44%) than did the control group (26%). It was also noted, from interview data that the trauma therapists reported a sense of alienation in both their professional and personal relationships following their work on the trauma response team.

In a study of Child Protective Service workers, Cornille and Meyers (1999) compiled survey and assessment data from 183 participants. This study collected responses on the Impact of Event Scale (IES-R) (Weiss & Marmar, 1995) which is used to assess specific secondary traumatic stress symptoms. They also used the Brief Symptom Inventory (Derogatis, 1975) to assess general psychological symptoms. On the average, these workers experienced a level of distress that is less than those of typical outpatient mental health clinics, but above those of the general population. Moreover, a

significant proportion experienced levels of distress above the levels reported by typical outpatient mental health clinics (13% of women and 9% of men).

Steed and Downing (1998) interviewed 12 female sexual assault/abuse therapists. The interviews revealed that all the therapists experienced negative effects of working with traumatized clients. These responses were primarily affective and included anger, pain, frustration, sadness, shock and distress. Several of the therapists reported awareness that they were using self-protective strategies with clients such as avoidance of traumatic content and dissociative reactions. Several also reported an increase in their sense of personal vulnerability and a decrease in their sense of professional identity.

Pearlman and MacIan (1995) used the Traumatic Stress Institute Belief Scale (TSIBS) in a study with 188 self-identified trauma therapists. The TSIBS scale was developed to measure disruptions in the seven cognitive schemas associated with vicarious traumatization (safety, self esteem, other esteem, self trust, other trust, self-intimacy and other intimacy). They used the Symptom Checklist-90-R (SCL-90-R) to differentiate general distress from trauma related distress. They also used the Impact of Event scale (IES) to assess avoidant and intrusive signs of PTSD. They found that therapists with personal trauma histories reported a greater degree of vicarious traumatization than those with no trauma history. Higher caseloads and longer time working with trauma clients also increased vicarious traumatization more in therapists with a personal trauma history.

In a review of fifteen quantitative studies that assessed for the impact of providing psychosocial services to traumatized populations (Bride, 2004) concluded that all fifteen studies found the presence of traumatic stress symptoms in service providers.

The degree of symptom impact varied across studies. In five of the studies the severity of trauma symptoms was estimated to be mild or not in the clinical range. The other studies found higher levels of traumatic stress symptoms. Several of these studies provided estimates of the prevalence of trauma symptoms among professionals. Arvay and Uhlemann (1996) found that 14% of trauma counselors had traumatic stress levels similar to outpatient PTSD clients. Meldrum, King, and Spooner (2002) found that 17% of case managers in community mental health services met symptom criteria for PTSD. Lastly, in a study of mental health workers who responded to the Oklahoma City bombing, 20.6% had moderate to severe levels of PTSD symptoms and 53.5% had moderate to extremely high risk for compassion fatigue (Wee & Myers, 2002).

In the specific area of vicarious traumatization effects in therapists who work with sex offenders the empirical support is sparser and more recent. In a comparison study of 347 clinicians who treat survivors of sexual abuse (N=95) and sexual offenders (N=252), Way, Van Deusen, Martin, Applegate and Jandle (2004) found that the two groups did not differ significantly in their levels of vicarious traumatization as measured by the IES. Scores for vicarious traumatization overall were higher in this group than those found in other clinician samples (Steed & Bicknell, 2001). Clinicians with shorter time providing sexual abuse treatment reported higher levels of vicarious traumatization.

Shelby (2001) used the Maslach Burnout Inventory (MBI) to examine burnout among 86 sex offender therapists. Compared to other mental health workers, sex offender therapists reported higher levels of emotional exhaustion and depersonalization. She also found higher levels of emotional exhaustion and depersonalization for sex offender

therapists in inpatient or prison facilities as opposed to community based treatment providers.

Steed and Bicknell (2001) completed a study of 67 sex offender therapists using the Impact of Events Scale (IES-R) which measures intrusive, avoidant and numbing responses to traumatic stress, and the Compassion Fatigue scale (CF) designed to measure secondary traumatic stress. 46.2% of their sample presented a moderate or higher risk of developing compassion fatigue. Burnout which is identified as being an indicator of secondary traumatic stress (Figley, 1995) was found high in 11.9% of the sample and moderate in another 16.4%. The IES-R results indicated that 15.4% were experiencing intrusive thoughts, 12.5% were experiencing avoidance and 8% were experiencing hyper-arousal. The newest therapists were most at risk for avoidance.

Farrenkopf (1992) interviewed 24 outpatient sex offender therapists to assess for psychological impact. She found that over half (54%) reported a shift in their treatment perspective, including reduced expectations and increased cynicism and pessimism about client change. 42% reported anger, frustration and decreased tolerance for others. 29% reported hypervigilance and suspiciousness of others. 21% reported increased feelings of exhaustion and depression.

In a survey of 53 sex offender therapists, Amen (2002) found that supervision or personal psychotherapy did not decrease the effects of vicarious traumatization. He also found no relationship between years of practice and any vicarious traumatization symptoms. Crabtree (2002) surveyed 158 sex offender therapists and found that they reported greater disruption of cognitive schemas on the TSIBS. She also found that

therapists with a personal trauma history had greater schema disruption than those without.

Kadambi (1998) surveyed 91 sex offender therapists to assess for the presence of vicarious traumatization. He used the TSIBS, the MBI and the IES. Sex offender therapists did display symptoms of vicarious traumatization as measured by the TSIBS. They were found to have moderate levels of emotional exhaustion, high levels of depersonalization and high levels of personal accomplishment (measured by the MBI) as compared to other mental health professionals. They did not report significant levels of intrusion or avoidance on the IES.

In general, empirical research demonstrates support for the concept of vicarious traumatization among clinicians, including sex offender therapists. There are several limitations in this body of research. Those studies which utilized quantitative methods relied primarily on survey data of which the participants generally self-selected themselves as "trauma therapists" (Bride, 2004). This is a poorly defined term and can render the findings less precise. Many of these studies used the Maslach Burnout Inventory and Compassion Fatigue scales, both of which were not designed as diagnostic tools but as early warning devices (Steed & Bicknell, 2001). They both tend to err on the side of over inclusion. The Impact of Events Scale has been used consistently to identify distress in a wide variety of populations (Cornille & Meyers, 1999), but there has been no agreement about what level of distress qualifies for a diagnosis of PTSD or secondary traumatic stress (Wilson & Keane, 1997). In almost all cases, the studies were designed to measure the impact that client trauma had on the therapists. This linear design in these

examinations is an over simplification of such a reciprocal interaction as psychological treatment.

Prevention

Several recommendations have been identified for the prevention and remediation of the effects of vicarious traumatization for clinicians. Gentry, Baranowsky and Dunning (1997) have developed an Accelerated Recovery Program for compassion fatigue. This five session treatment protocol includes identifying triggers and symptoms, acquiring self-care skills and enhancing interpersonal professional support. Figley (2002) recommends employing desensitization techniques and enhancing social supports. The Child Trauma Academy has developed a protocol of self-care strategies that addresses physical, psychological, emotional and workplace domains for professional care-providers (Perry, 2003). Joslyn (2002) has commented on the efforts of charitable organizations to actively prevent employee burnout. These efforts include education about symptoms, establishing support systems, encouraging affect expression, facilitating self-care and sponsoring outside assistance and support.

Clemons (2003) describes the ABC's of self care for social workers. A is for self awareness. B is for the balance of healthy boundaries between work and personal life (self-care). And C is for connection to healthy support systems. She also recommends organizational responsibilities that include facilitating support groups and in-service training. Recommendations based specifically upon Constructivist Self-Development Theory include: diversifying case load to limit the effects of working with traumatized clients, increasing education and training regarding the effects of vicarious

traumatization, developing strong social support networks (including formal and informal professional support), and specifically addressing spirituality issues to counter the negative impact on the professionals' sense of meaning (Trippany, *et al*. 2004).

Warnings are offered that if the effects of vicarious traumatization are not managed in positive ways, they can inadvertently be managed in negative ways (Ruzek, 1993). Lindy (1988) has identified therapist's defenses which he judged to interfere with the therapy process. These include distancing from the client through "avoidance, disavowal and clinging to the professional role," as well as distancing from one's own feelings by "isolation, generalization and intellectualization." Dalenberg (2000) also warns in her discussion of counter-transference that suppression of affect could be a disguised version of PTSD. She also recommends emotional disclosure to a support system regarding the indirect experience of the client's trauma as a means to keep those effects from damaging the therapy process and perhaps even the client.

CHAPTER III

Methodology

Qualitative Research Strategy

Drawing on my own experience of three years as a sex offender therapist, I have a working knowledge of many of the models of sexual deviancy that drive sex offender treatment. Sex offender treatment methods generally represent an application of theories of human behavior developed in other domains such as substance abuse and anger management treatment, and then applied to sex offender treatment. These approaches to sex offender treatment are examples of theory preceding research. The inconsistent findings regarding the support for these models is partly a product of the attempt to fit theory to the data. In exploratory interpretive research this process is reversed, in that the data precedes the theory. The theory emerges from the data through the process of inductive reasoning. According to Bogdan and Biklen (1992) qualitative researchers do not search out data or evidence to prove or disprove hypotheses they hold before entering the study. Instead, abstractions are built as the particulars that have been gathered are grouped together. The researcher develops theoretical propositions out of the data in a process that is seen as moving from the particular to the general. Explanation and theory are developed directly from the analysis of the emerging data through a process called the constant comparative method (Glaser & Strauss, 1967). Glaser (1978) describes the steps in the constant comparative method as follows:

1. Begin collecting data.
2. Look for key and recurring issues in the data that become categories of focus.
3. Collect more data that can provide many incidents of the categories of focus with an eye for finding diversity in the categories.
4. Write about the categories (analytic memos) attempting to describe and account for all the incident's that emerge from the data.
5. Work with the data and attempt to discover basic social processes and relationships.
6. Engage in coding and writing in depth as the analysis focuses on the core categories.

An exploratory approach was strategic in my attempt to derive an improved understanding of the process of sex offender treatment from the views of the sex offender therapists that participated in this study. In new fields of study, where little work has been done and little is known about the phenomenon, exploratory qualitative research is a reasonable beginning point for research (Patton, 2002).

Nature of the Question

The purpose of this study is clearly stated in the title. The question I answer is "What is it like to be a sex offender therapist?" This is the kind of question that does not lend itself well to an objectivist exploration. An answer to that question can only be provided by a sex offender therapist. It is a question of meaning. Symbolic interaction is a social-psychological approach that places primary emphasis on the importance of

meaning and interpretation as essential human processes (Patton, 2002). Blumer (1969) has identified three major premises as fundamental to symbolic interaction:

1. Human beings act toward things on the basis of the meaning that the things have for them.
2. Meaning arises out of social interaction with others.
3. Meaning is managed and modified through an interpretive process used by the person in dealing with the things encountered.

According to Blumer (1969), these premises imply that qualitative research methods are those best suited to attempts to explore how people attempt to understand and interpret their world. Research entails directly interacting with people in as open-minded and naturalistic a way as possible. Then through inductive analysis the researcher comes to understand the symbolic world of the subjects being studied. The goal is to shed light on what is most important to the people being studied. The researcher attempts to put herself in the place of those studied, as Psathas (1973) relates:

The implication of the symbolic interactionist perspective is that the actor's view of actions, objects and society has to be studied seriously…. The meanings of objects and acts must be determined in terms of the actor's meanings. The role of the actor in the situation would have to be taken by the observer in order to see the social world from his perspective (p. 216).

Assumptions

For the purposes of this study, the following assumptions are made

1. Sex offender therapist's responses in this study were forthcoming and

honest as no incentives were given and each participant freely gave of her or his own time to be interviewed.

2. The nature of working as a therapist with sex offenders is fundamentally different from working with general population clients.
3. Since a small purposive sample was used, the results do not necessarily generalize beyond the sex offender therapists who participated in this study.

Sample Selection

Purposeful sampling was used in this research project. This form of sampling provided the most efficient method for obtaining subjects most appropriate for this type of investigation. It permitted inquiry and allowed understanding of this phenomenon in depth. The logic and power of purposeful sampling derive from the emphasis on in-depth understanding (Patton, 2002). This leads to selecting information rich cases in order to learn a great deal about the issue of central importance. The subjects in this study consisted of twelve sex offender therapists, all of whom had at least three years experience as sex offender therapists. The length of experience ranged from three to thirty years. The therapists had the equivalent of a Masters degree or greater in a mental health related field. They ranged in age from 36 to 61. Eight of the therapists were men and four were women.

Initial contacts were made through the state Department of Corrections sex offender treatment program. Other contacts were garnered from referrals made by early participants in the study. Sex offender therapists were initially contacted by phone to assess their willingness to participate in the study. Face to face interviews were

conducted with each individual who agreed to participate. The interviews were conducted primarily at the site in which the sex offender therapist worked, with the exception of four of the interviews which occurred in the participants homes. The purpose of the study was described in the consent form (see appendix A) which was reviewed and approved in the study application by the I.R.B. Each individual read and signed the consent form before the interview began. All interviews were audio recorded with participant approval.

Interviews

I conducted each interview personally. Each participant was only interviewed once and each participant was informed that he or she would be provided with a summarized report of the outcome of this study upon request. The interviews lasted approximately 90 minutes. Several topics were covered during the interviews. Since the goal of this study was to attempt to capture the complexities of the participants' individual experiences as sex offender therapists, the interview strategy was primarily unstructured. I did not rely completely upon an informal conversational interview style throughout the study because I did have a general set of issues to explore with each participant. I conducted the interviews in two stages. The initial set of interviews were more informal in an attempt to allow more general issues related to sex offender treatment to emerge from the experience of the therapists themselves. The unstructured interview style in the first phase offered maximum flexibility to pursue information in whatever direction appeared to be appropriate, depending upon what emerged from the setting. The necessity of sensitizing concepts such as the nature of sexual deviancy, therapist's reactions to sex offenders, and the overall purpose of the inquiry informed the

first phase of interviewing. Within that overall guiding purpose, as the interviewer, I was free to go where the data lead (Patton, 2002). Lincoln and Guba (1985) describe this process of allowing the research direction to emerge from succeeding steps as critical in order for the inquiry to be steeped in the area under study. Succeeding methodological steps are based upon the results of steps already taken. This requires the presence of a continuously interacting and interpreting investigator.

An interview guide (see appendix D) was prepared to insure that the same basic lines of inquiry were pursued with each person interviewed in the second phase. The advantage of an interview guide is that it makes sure that the interviewer has carefully decided how to best use the limited time available in an interview session. The guide helped make interviewing a number of different people more systematic and comprehensive by delimiting in advance the issues to be explored (Patton, 2002). No participants from the first stage of interviews participated in the second round of interviews.

After transcription and a preliminary analysis of these early interviews, I presented preliminary findings back to the therapists I had interviewed. I asked if I had accurately represented them and for any further information they might provide to discern more specific issues. A second group of participant interviews was conducted with the guidance of information from the first group. The second phase of interviews was also generally unscripted in an effort to afford the sex offender therapist's maximum flexibility in their responses, but the sensitizing concepts used with the second group were those that emerged from the first phase of interviews. This second group of interviews was also open-ended in nature but more specific in subject matter in order to

more deeply explore the predetermined subject. A second interview guide (see appendix E) provided topics or subject areas within which the participants were free to explore. I also followed up on a selected number of this second group of therapists to assess that I had accurately represented them in my interview transcripts and preliminary analyses.

Data Analysis

Inductive data analysis is more likely to find and take into account the multiple realities inherent in exploratory research (Lincoln & Guba, 1985). Such investigation is more likely to make the interaction between researcher and participant more explicit. Inductive analysis is therefore more likely to identify and address those mutually shaping influences that arise from the study. The meanings and outcomes of the study are negotiated between the researcher and the participants. Qualitative and exploratory research aims to generate propositions that correspond to real-world phenomena (Patton, 2002). I transcribed each interview myself as I believe this was an important preliminary step in a thorough analysis and understanding of the data provided by the participants. Once the recorded interviews were transcribed, data analysis began with basic description. Data analysis then moved toward a conceptual ordering of the data into discrete themes. Specific categories that I anticipated emerging included: conflicts between client support and community protection, managing reactivity to sexually deviant content, professional identity maintenance, and dealing with the efficacy of sex offender treatment. This list is only partial and represents my own biases resultant from both working with sex offenders and examining related literature. Throughout the coding and analysis process, I engaged in a systematic search for alternative themes, different

patterns, and rival explanations to enhance the credibility of my findings (Patton, 2002). I persistently attempted to be personally reflective and aware of my biases in the analysis of the data collected in this study through the use of regular journaling and peer consultation.

Once the new themes were identified, they were labeled with a code and an explanation of that code. I employed the constant comparative method of analyzing qualitative data proposed by Glaser and Strauss (1967). This method involves four stages: (1) generating categories, (2) integrating categories, (3) delimiting categories, and (4) writing the emerging theory. Strauss and Corbin (1990) further describe the procedure of generating categories as open coding, which involves breaking down the data into discrete parts that are later stitched together again through theoretical connections. The data that have been fragmented by open coding are then put together again through what Strauss and Corbin call axial coding (Dey, 1999). After each interview was transcribed and coded, I engaged in an arduous process of analytic memo writing in an attempt to submerge myself in the data. Memo writing is the crucial intermediate step that moves the analysis forward. Memo writing prompts the researcher to raise the codes to conceptual categories from the data(Charmaz, 2000). I completed analytic memos addressing each of the generated categories from separate interviews. The memo process graduated from there to addressing the integrated themes that were present in all the interviews. These integrated themes were then collapsed into the thematic headings that have been addressed separately in the analysis section of this study.

The final stage dealt with the core categories around which the inquiry revolved. During this phase I focused on the relationships between the categories. This process

takes qualitative data analysis beyond mere description and into a conceptual mode of analysis. This stage required returning to the literature to assess how these findings might be corroborated by other established domains of research. It is my hope that a better understanding of the clinicians' experience as a sex offender therapist will become more evident from this conceptual mode of analysis.

Dependability

A good qualitative study is well documented with description taken from the data to illustrate and substantiate the assertions made. There are no formal conventions used to establish truth in qualitative research (Bogdan & Biklen, 1992). Data are presented as if they originate from a source other than the author and represent the opinions of the persons being studied (Golden-Biddle & Locke, 1997). Lincoln and Guba (1986) propose that qualitative research demands different criteria from those inherited from traditional social science research. They suggested dependability as an analog to reliability, and credibility and transferability as an analog to validity. They viewed these criteria in combination as addressing the issue of trustworthiness. Merriam (1998) recommends several methods for improving dependability and credibility in qualitative research. Among these are, member checking, triangulation, peer review, use of multiple cases and detailed procedural accounts for data collection and analysis. All of these measures listed were included in this study.

The following steps were taken in this study to assure the dependability of the findings. Vogt (1999) has defined inter-rater reliability as the extent to which two raters judge phenomenon in the same way. After transcribing and coding the interviews myself, another individual familiar with qualitative research reviewed and coded a sample of the

transcripts. She had prior experience in coding methods but was not familiar with the purpose of the study. Having her remain blind to the purpose of the study was an effort to maintain potential bias at a minimum. The result was a high level of agreement between the themes identified by each of us.

Credibility

Questions of credibility are inquiries as to how much the inferences drawn from a study are correct. To contribute to the credibility of this study, multiple interviews were conducted. This allows for the comparison both within and across interviews (Morgan, 1983). Studying successive interviews helps the researcher to stay close to the studied empirical world and thus lessens the probability that she will force borrowed or biased concepts onto it (Charmaz, 2000). Twelve interviews were conducted. Each of the interviews was coded separately with no imposed set of categories initially. While there were minor differences across transcripts, identifying trends and patterns of responses did emerge. The occurrence of such patterns and trends aids to strengthen the claim of the credibility of the data collected in this study.

Crabtree and Miller (1992) suggest using multiple methods to insure credibility. Two separate member checks were conducted as part of the data collection and analysis conducted in this study. The first member check consisted of returning to a sample of the first group of participants after their interviews were transcribed. The interviews were reviewed by the participants who then provided feedback as to whether they felt the transcripts accurately portrayed their perspectives. This feedback was incorporated into subsequent interview procedures to better align the emerging design of this study with the experience of working with sex offenders described by the participants. Member

checking also allows the participants to review the researchers interpretation of the data collected (Bogdan & Biklen, 1992). The second member check followed completion of early coding procedures in order to examine how well the codes captured participants' implied and explicit meanings. A second sample of participants was re-contacted and asked to provide feedback in response to reviews of initial coded themes and analytic memos related to those themes. This second member check proved especially fruitful in correctly delimiting the categories and constructing the overall theme of the study.

According to Patton (2002), an important indicator of credibility in qualitative research is the search for alternative explanations for the data. The search for the best fit requires assessing the weight of the evidence and searching for those patterns and conclusions that fit the preponderance of data. In this study, the original discoveries anticipated were not supported. The over-riding patterns that emerged in the data required a return to the literature to explore an area in which I was unfamiliar (vicarious traumatization).

Peer review of the data is a method for insuring the trustworthiness in the researcher and credibility of the data. Peer review was established through contact with the dissertation advisor and other committee members. Other professional peers were consulted as a regular part of the review process.

Qualifications of Researcher

I expected that my own experiences as a sex offender therapist would prove to be a mixed blessing in this study. On the positive side, I was able to draw directly from my experiences to facilitate interactions with the sex offender therapists that elected to

participate in this study. To some degree, I was already familiar with their specialized professional language and had less difficulty with technical aspects of a discussion of sex offender treatment. I was able to draw upon my own experience in the role of a sex offender therapist as these factors contribute to the theory and methodology of sex offender treatment. In discussing the methodological considerations of research from a symbolic interactionist perspective, Blumer (1969) asserted that no theorizing, however ingenious, and no observance of scientific protocol, however meticulous, are substitutes for developing a familiarity with what is actually going on in the sphere of life under study. Lincoln and Guba (1985) state that an advantage of beginning with this fund of knowledge is that the investigator can have a sense of what the salient factors are, think of ways to follow up on them, and make continuous changes, all while actively engaged in the inquiry itself. As Becker states (1987) the nearer we can get to the conditions in which the participants in a study actually attribute meanings to objects and events, the more accurate our descriptions of those meanings will be. My three years of direct experience as a sex offender therapist has provided me unique perspectives into the lives of sex offender therapists. My former position in this professional community afforded me access to many colleagues still engaged in sex offender treatment.

A major shortcoming of my experience as a sex offender therapist has the potential to directly impact the central objective of this study. As a former sex offender therapist, I worked directly from the primary models from which sex offender treatment is derived. My biases regarding sexual deviancy and the theoretical basis of sex offender treatment are already at a developed stage. Spindler and Spindlers'(1987) guidelines for qualitative research state that hypothesis should emerge *in situ*, as the study goes on and

in the setting selected for observation. Judgment on what may be significant to a study in depth is deferred until the orienting phase of the study has been completed. My own biases could directly compromise my ability to allow the understanding I am attempting to discover to arise from the data provided by the participants in the study. To address this obstacle, I endeavored to be forthcoming and reflective with the nature of my own biases and attempted to reconcile their potential influence on my analysis of the information provided by the participants. Lincoln and Guba (1985) claim that the *human instrument* is still the logical choice for qualitative research. This assertion rests on the fact that only the human instrument is sufficiently adaptable to adjust to the varieties of reality that will be encountered in this kind of exploratory research. All research instruments are value based, but only the human is in a position to identify and take into account to some extent those resulting biases.

Ethical Considerations

An informed consent form (see appendix A) described fully for the participants the purpose for collecting the information. It included the provision that any participant was free to withdraw from the study at any time. No financial compensation was offered for participation, but a summarized report of findings was provided to each participant upon request.

The potential existed for psychologically stressful reactions from participants in this study, as the content addressed perhaps uncomfortable aspects of their work. No undue pressure was exerted upon participants to explore areas of their work which impelled them beyond issues they were comfortable disclosing. Participants who

experienced an unfavorable reaction to the interview procedure were able to pursue a referral number provided on the informed consent form to address these reactions through an appropriate outlet other than the interviewer if needed.

Identifying information has been coded for transcripts and all other generated records. All identifying information of participants remains confidential and will not appear in any data records or reports. All tape recorded interviews have been erased. All transcribed interviews remain in my possession for a period of one year after the data analysis is completed, at which time they will also be destroyed. Transcripts have been stored in a locked and secure location during this time.

Significance of the Study

Sexual offenses continue to be a socially significant and complex problem. The emotional and psychological impact on victims and their families can be devastating. Inconsistent findings regarding the efficacy of sex offender treatment continue to undermine professional and public support of these efforts to prevent sexual abuse (Marques, 1999). A better understanding of the definition of sexual deviancy which guides sex offender treatment could have profound implications. This improved understanding could serve to better guide both preventative and remedial interventions in alleviating the problems of sexual abuse. A more delineated understanding regarding sexual deviancy and sex offender treatment could result in a more effective delivery of treatment. This could result in both more treatment successes and improved measurement procedures in outcome studies. This improved understanding could better inform

professional and public support for the effectiveness and thereby the importance of sex offender treatment programs.

A further benefit might be that a clearer understanding of sex offender treatment could contribute to the training of sex offender therapists becoming more formalized where now no formal training for sex offender therapists exists (O'Connell *et al*., 1990). There is the issue of high burnout rates among sex offender therapists (Shelby, 2001). A clearer picture of how working with sex offenders affects sex offender therapists could lead directly to measures to employ to alleviate some of those negative effects. The prospect for gains in either of these areas clearly warrants the exploration.

CHAPTER IV

Analysis

The purpose of this study was to answer the question, how do sex offender therapists describe their work? Therapists in general are called upon to be empathic and supportive and above all to attend primarily to the needs of the client (Yalom, 1995). Yet, the therapist must control her own emotional needs and responses in interactions with the client. Sex offender treatment, while still containing many of the qualities of a therapeutic relationship found in general therapeutic work, possesses qualities unique to working with this population (Flora, 2001). The goal of this study was not specifically to discern those unique qualities, but instead to address the therapist's reactions to working with sex offenders and the ways they deal with those reactions. A symbolic interactionist approach to research necessitates a formal study of the social world (Downes & Rock, 1988). I will be attempting to draw on the symbolic interactionist perspective, and through my interactions with the participants, to find meaning in their descriptions of their experiences as sex offender therapists. In order to ground an understanding of how sex offender therapists are affected by their work with sex offenders it will be important to relate how the sex offender therapists perceive and define what it is they do. This analysis will proceed in three separate sections. They include: 1) an overview of the world of the sex offender therapist; 2) how the sex offender therapists are affected by the work; and 3) how they attempt to manage those affects.

The following overview of the world of the sex offender therapist includes the participant's descriptions of their thoughts and observations about sex offenders. It also includes descriptions of the process of sex offender treatment and some of the etiological theories of sexual deviancy as they pertain to treatment. How clinicians describe other people's reactions to them and to sex offender treatment is described. The participants also describe their reasons for doing this work.

The section that addresses the effects of being a sex offender therapist introduces the concept of vicarious traumatization. The participant's descriptions of how the work affects them is presented using the framework of secondary traumatic stress described by Figley (1988). The secondary traumatic stress model mirrors PTSD diagnostic criteria but at sub-clinical levels. This framework is used in this analysis as a template to organize themes and their relationships to each other in the data. The PTSD diagnostic criteria is not the only framework for understanding participants reports. McCann and Pearlman's (1995) vicarious traumatization framework is briefly presented as an alternative descriptive model as well.

The final analysis section includes the participant's descriptions of their efforts to manage the effects of working as sex offender therapists. These descriptions focus primarily on efforts to process their reactions interpersonally through supportive venues such as supervision and professional support.

The World of the Sex Offender Therapist

The participants in this study had much to say about the reality of being a sex offender therapist. In the following analysis of their comments, the material is addressed

in four distinct categories: understanding sex offenders, understanding sex offender treatment, dealing with other people, and reasons for being a sex offender therapist.

What are the specific behaviors of sex offenders in sex offender treatment that elicit negative reactions from sex offender therapists? Most of the reported emotional reactions cited were in response to the content disclosed by the sex offender during treatment. The sex offender therapist's interviewed in this study reported extensively on behaviors of sex offenders while in treatment that gave rise to negative responses. The majority of the negative responses were to the descriptions of sexual offenses. The reactions were strongest to sexual assaults committed against children.

Sex Offenders

In talking with sex offender therapists about the sex offenders themselves, the issue of why sex offenders commit sexual assaults and what makes them do it were often prefaced with the notion of what is it that makes sexual deviancy wrong? The responses to this line of inquiry centered upon the concept of consent. Consent was the starting point at which the objections to sexual deviancy sprang. Carla described how she thought otherwise before becoming a sex offender therapist, but that her view changed afterward.

> I thought it was the behaviors but it's not. It's whether or not it's consensual. They can do it with spiders and chicken breasts if they want to, as long as they're not hurting other people.

What is it about sex offenders that make them different? Several theories have been formulated in attempts to shed light on this question. The sex offender therapists in this study commented widely on this issue. Three recurring kinds of comments did not fit

clearly into the discussion of sexual deviancy theories that follows later in this analysis. These specific comments were more descriptive of personality traits of sex offenders than they were of theories of sexual deviancy. The sex offender therapists found sex offenders to be particularly narcissistic, manipulative and over-sexualizing.

Narcissistic individuals tend to have a lack of empathy for others and difficulty recognizing other peoples distress (Zuskin, 1992). The relationship between narcissism and sexual offending is not only intuitive, there is evidence that a large number of individuals referred to criminal justice or mental health professionals for sexual deviancy exhibit narcissistic and antisocial disturbances (Flora, 2001). Nelda offered a thorough account of her observations of narcissism in sex offenders.

> It's kind of like when they hurt it's huge but when somebody else hurts it's deflected. You will find that similarity in all these men.

The second prevalent personality trait was the tendency toward being manipulative and dishonest. Sex offenders often experience difficulty being truthful. Criminal justice and mental health professionals cite this as one of the most common characteristics or behaviors found in offenders (Flora, 2001; Polsom & McCollom, 1995). It's not just that sex offenders are manipulative, but that they are highly skilled in this area. Nelda described how being manipulative is an essential skill that a sex offender needs in order to even commit sexual assaults.

> Trust is what they use to offend with. What they will manipulate is trust.

One form of manipulation used effectively by sex offenders is the presentation of themselves as especially virtuous people. Sexual assaults committed by clergy are glaring examples of this ruse (Szasz, 2002). Often, other people such as neighbors and co-

workers are shocked that such a benevolent and helpful person could have committed such an act. Sex offenders are often the last people that anyone would suspect. This phenomenon contributes distinctly to calls of false accusation which are historically prevalent when sexual assault victims come forth (Salter, 1988).

The therapist must guard against sex offenders who may be skilled at getting others to see them in a positive light. These sex offenders will be able to quickly figure out what they think the therapist wants to hear. They will be able to relate seemingly empathic responses about their victims while displaying shame and remorse (O'Connell, *et al*, 1990). Rather than seeing such behavior as progress, the therapist has to stay cognizant of the offender's potential to manipulate. Curtis offered this cautionary description of how skilled this manipulation can be.

> And it's one of the things that I always say to people is that these guys will number one; they'll make you whatever you want to be. They were going to know my weaknesses before I even admit them. And they will exploit them.

He described how he needed to find a sense of balance in working with sex offenders by noting that this vigilance against manipulation could become a problem in itself. However this need for balance still did not warrant dropping his vigilance.

Sex offender treatment heralds accountability and accepting responsibility for one's behavior as cornerstones to effective treatment (Flora, 1992). This requires consistent, honest self disclosures on the part of the sex offender. Sex offenders are not renowned for honest self disclosures. Sex offenders do not tend to be fully open and honest about their sexual thoughts and behaviors, even with themselves (Salter, 2003).

When sex offender therapists determine that sex offenders are being dishonest it can be interpreted as rejecting or resisting treatment.

Another common trait that the participants commented on was the sex offender's tendency to sexualize differently than most people (Weiderholt, 1992). Sexualizing refers to the process of interpreting some stimuli as sexual. Salter (1988) uses an alcoholism analogy in her discussion of how the sexuality of sex offenders is different. As the alcoholic resorts to alcohol as a means to address or avoid his problems in life, so the sex offender resorts to sexualizing. Neal told this story from early in his career as a sex offender therapist. He describes an incident in which he was sitting in a treatment group and watching a video that depicted a violent rape.

> I looked at the rapist sitting beside me and he said, 'You know, to me it sounded like she really kind of enjoyed it.' And it was one of those moments where suddenly I realized, Whoa. You heard something really different than I heard.

Larry described the difficulty he had in understanding how sex offenders could interpret the behavior of children in sexual terms.

> To listen to people who would attribute sexuality to a child that age was pretty difficult initially.

When confronted with the sex offenders' clearly different way of interpreting sexual stimuli, the clinician is challenged to come up with some explanation for why.

Etiological Theories of Sexual Deviancy

Specific theories of sexual deviancy and the etiology of sexually deviant behavior definitely are salient issues for sex offender therapists. The theories discussed below do

not represent a thorough address of these theories. These comments instead represent how the sex offender therapists in this study draw on these theories in their work with sex offenders. Most of the comments are recollections of encounters with the sex offenders in treatment in which some salient aspect of the theory was either illustrated or guided the sex offender therapist's approach to the offender. The issues related to etiological theories of sexual deviancy addressed here include: empathy deficits; social inadequacy; pedophilia; power and control issues; learning and reinforcement; and childhood victimization of the offender. The participants addressed the absence of an adequate theory to explain sexual deviancy and the problem that defining deviancy itself presented.

One theory is that sex offenders have an empathy deficit. This theory is mostly based on the logical assumption that if they realized how much pain they inflicted on their victim, then they would not commit the sexual assault (Garlick, 1996; Salter, 1988)). Nelda provided a chilling account of her understanding of the empathy deficit in sex offenders. Her description clearly suggests that the sex offender is a completely different kind of person than most.

> I don't think you can throw somebody against the wall and get it. He gets it on one level which isn't very useful to him, which is arousing. He doesn't get it on a human level. He needs to understand this in a way that you and I do.

Another theory suggests that sex offenders resort to sexually assaulting children because of inadequate social skills or self esteem (Freund, 1972; Gebhard, 1965). This theory suggests that they are unable to engage meaningfully enough with adults to meet their own sexual and intimacy needs. Several of the sexual offender therapists put some credence in this theory. Mark gave this description.

> I do think there is the fellow who really is so inadequate, just lacks any ability to initiate and maintain relationships with adults, females, and turns to children just as the only option he sees available.

In Carrie's view of sexual deviancy, this explanation accounted for a very high proportion of sex offenders.

> They're socially stuck or emotionally stuck in a child stage and they think of themselves more as children. They feel accepted by children where as they're not with adults.

The next explanation is a version of the concept that they were just born that way. A pedophile is a person who just happens to be sexually aroused to children. In this theory, pedophilia is merely a rarely occurring statistical deviation (Revitch & Weiss, 1962; Salter, 2003). Carrie discussed her attempt to grasp this issue.

> There are people who are attracted to children, sexually attracted to children, just like there are people who are sexually attracted to adults of the same sex and adults of the opposite sex.

A very unsettling aspect of this theory is that treatment can have no effect on the true pedophile. Mark suggests that the problem is serious and entrenched. He provides an account of his bleak prognosis for pedophilia.

> How does a person develop a sexual interest in children or pedophilia? It just happened. The cards are dealt. It's much more in the hardwiring than it is the software.

The issue of power is frequently employed in the analysis of sexual deviancy (Gratzer & Bradford, 1995). In this view sexual assaults are exertions of power and dominance over the victim. Eve described it like this.

> It's not the sexual urge that you need to stop, the urge to have sex, um it's about what goes on in their head and then connecting the sex with the violence or the sex with the power and control. And so that's what you need to break.

A fairly straight forward theory is that sexual deviancy is a learned behavior (Langevin, 1990). This theory is consistent with relapse prevention approaches to sex offender treatment. The issue of deviant arousal is secondary to a focus on intervening on the enactment of sexually deviant behavior. Nelda summarized this theory.

> I believe there's nothing stronger than pairing a stimulus with a physiological response such as orgasm. They teach themselves deviant arousal. If you masturbate to a pair of snowshoes long enough you will be attracted to snow shoes.

A final explanatory theory that was discussed was the idea that the sex offender was a victim of sexual assault himself as a child and that had something to do with why he became a sex offender (Briggs, 1995). While this is a very common belief among sex offender therapists and the general population as well, the process itself is not very well understood (Pfafflin, 1992). Sam described his thinking about this theory. For him, seeing the sex offenders as victims themselves helped him feel more compassion for them.

> I believe in the good in people, and I believe that they're doing the best they can with what they've got. Behind most abusive men was a hurt little boy.

Wallis (1995) has described how in this model, the child victim cross-identifies with the offender. The offender becomes a mentor for the child in amoral sexual development. Kevin provided an account of how he wrestles with this issue in his attempts to understand sexual deviancy in his work with sex offenders.

> Their own abuse is not a way of excusing their behavior; it's a way of explaining it though.

The overlap, inconsistencies and sparse empirical support for these varied theories of sexual deviancy suggest a lack of coherent direction for treatment provision. Rosenhan (1975) has stated that,

> Whenever the ratio of what is known to what needs to be known approaches zero, we tend to invent knowledge and assume that we understand more than we actually do. We seem unable to acknowledge that we simply don't know. The needs for diagnosis and remediation of behavioral and emotional problems are enormous. But rather than acknowledge that we are just embarking on understanding, we continue to label patients…as if in those words we had captured the essence of understanding (p.257).

As if in response to Rosenhan, a comment by Mark concludes this overview of the varied theories sex offender therapists draw on in their work with sex offenders.

> To this day nobody knows how sexual deviancy gets started. The why questions are always masturbatory (laughs). Us guys out here on the front lines you know we're not so worried about the whys.

This comment in some ways suggests an almost atheoretical approach to sex offender treatment. In fact, several of the sex offender therapists did comment that the

question how did this man become sexually deviant? is not too relevant in their approach to treating him. Larry offered a comment similar to Mark's, but with an unsettling conclusion.

> I don't think that there's a blanket or general theory for sexual deviance. I think people have deviant sex for all the same reasons they have appropriate, normal sex.

Larry's comment is unsettling in that in a way it raises the question "Is sexual deviancy actually deviant?" Nelda said this on the topic.

> I think we all have fantasies that we don't act out. I think we all want to steal and murder and all those things.

Her comments are consistent with the research of Neil Malamuth (1985). He found that sixty percent of American men admitted that they would force a woman to commit sexual acts against her will if assured that they would not be caught. Groth (1979) an expert on sexual aggression, has stated that when we are talking about sexual assault, we are talking about behavior that anyone could exhibit. Mark offered this version of the same sentiment.

> Every guy walking the face of the planet probably thinks about it on some level, some brand of deviancy. It's just that most men don't act out on those thoughts.

Nelda offered a warning about the possible consequence of pursuing the distinction between us and them too ardently.

> If you try to square this you're in deep shit. Because it's either going to be that the man is a total washout or society is wrong.

Sex Offender Treatment

Sex offenders present difficult clinical problems that challenge traditional methods of psychological treatment (O'Connell, *et al*, 1990). Sexual crimes impact the victim and the community in a manner that other crimes or mental disorders do not. Working with sex offenders requires a unique knowledge base for the therapist. As a discipline, sex offender treatment is still in the early infancy stages of development (Flora, 2001). The participants in this study described what they considered the most relevant aspects of sex offender treatment itself. Therapy with sex offenders is very different from therapy with the general population. Much of the discussion focused on these differences.

An early difference noted was the issue of problem definition. The participants discussed the issue of holding the sex offender accountable for the sexually deviant behavior. This was described as an overtly direct process of confrontation. And finally the participants discussed the conflictual nature of developing a therapeutic alliance with the sex offender, especially as this alliance relates to issues of confidentiality.

Accountability

Generally, psychological treatment begins with the process of defining the problem. The client and the clinician attempt to collaboratively come to a working definition of what the exact problem is that has brought the client to therapy. In the case of sex offender treatment the problem has been clearly defined even before the therapist and the client meet. Most often, this problem definition has been determined by someone other than the client himself (Flora, 2001). A critical aspect of sex offender treatment is

to get the sex offender to agree to the definition of the problem to be addressed in treatment. Sex offenders do not come to treatment voluntarily and are generally resistant to treatment (Salter, 1988). More specifically, the sex offender has to admit that he has a problem. The sex offender therapists in this study called this issue accountability or holding the sex offender accountable. Sam talked about how this was the first point of business. First you take responsibility, responsibility for what you've done to others, then your own needs will be attended to. They had to admit that they were a sex offender.

The method for bringing the sex offender to accountability was revealed as a very direct one. It involved confronting any and every departure from the sex offender accepting full responsibility for his sexually deviant behaviors. Yochelson and Samenow (1986) endorse this direct approach for the treatment of all criminal behavior. Confrontation in sex offender treatment was presented as a necessarily very direct procedure, as Kevin notes,

> Sex offender treatment basically focused on addressing and confronting cognitive distortions.

Confrontation whether gentle or forceful, is necessary for sex offenders to change. They will not spontaneously abandon well-practiced, cognitively supported, and emotionally satisfying behaviors simply because they have been discovered (O'Connell, *et al*., 1990). Although sex offenders may state their intentions to change, they are more likely to expend their energies covering, defending and rationalizing their behavior. The sex offender therapist must be willing and able to confront these rationalizations and deception. Neal describes his experience as well as alluding to the necessity of it.

> You try to break down their defenses, you tell them they're in denial, you point out all the mean, horrible things they did. We had the one approach and that was hit them with both barrels.

Curtis provided the most adamant example of the use of confrontation as well as a thorough explanation of the necessity of using this procedure with sex offenders. His statements reflect his position that the sex offender therapist who fails to follow through with direct and appropriate confrontation does offenders and the community a disservice.

> If he needs me to take my knife out and gut him, I can do that. You know it's just, which do you want? You know so it's his choice. Right is right, and if he doesn't do right, then I get on him.

The primary objective of sex offender treatment is for the sex offender to never sexually assault anyone again (Salter, 2003). The mantra for sex offender treatment is no more victims.

Therapeutic Alliance

There are other central aspects of therapy that are unique specifically to sex offender treatment. One of those very different aspects is the therapeutic alliance. The therapeutic alliance is considered centrally important across therapeutic models (Yalom, 1995). In sex offender treatment the therapeutic alliance manifests rather differently. Sex offender therapists are not immune to having the same negative reactions to the realities of sexual abuse that much of society does. This presents a clear obstacle to identifying with the sex offender and forming an empathic therapeutic alliance. This issue will be

addressed later in the portion of the study that addresses therapists' reactions to sex offenders.

What needs to be addressed at this point is another aspect of the therapeutic alliance. Who exactly is the client that the therapist is to be in an alliance with. Identifying who exactly is the client proved to be an obstacle related specifically to the process of sex offender treatment. It is a prevalent attitude among sex offender therapists that society is the client and not the offender himself (Flora, 2001). The sex offender not being the actual client could clearly hinder the formation of a therapeutic alliance with him. This issue relates more to the structure of treatment than to the process. For many of the therapists in this study the client is clearly not the sex offender. Sam is unambiguous about who his client is.

> The primary client is the public. That's more important than the healing of the individual. I'd do whatever I could to protect the public from a sex offender.

Carrie allows room that both society and the sex offender are the client, but she is clear about whose interests come first. She offered a sound reason why she does not align with the sex offender.

> Compassion is something that the therapist is supposed to have. Well not here. My feeling was that you're not supposed to have compassion because they use the compassion to get you.

Another very different aspect of sex offender treatment when compared to general therapy is the issue of confidentiality. Confidentiality is a cornerstone of therapy. The violation of a client's confidentiality is a serious infraction that can have devastating consequences for the client personally and the therapist professionally (Bersoff, 1976).

Yet that is not as clearly the case for sex offender treatment. In fact, if the client discloses information about a sexual assault he has committed against a minor, the therapist is legally obligated to report that information. Obviously, these kinds of disclosures can be commonplace in sex offender treatment because sexual assaults against minors are often the primary topic addressed in treatment. Larry described how there is a specific way that sex offenders can talk about unreported crimes that is necessary therapeutically but still does not cross over into the domain where he, as the sex offender therapist, is required or even able to report the crime. He described how he actually coaches sex offenders in what this way of disclosing details of past sexual crimes is. He offered a theory as to why it is important for the sex offender to be able to discuss these past crimes.

> I can effectively treat an offender and never know any kind of identifying information about the victims. I'm going to be very quick to explain both legal issues and confidentiality issues up front. If he tries to take me into that discussion to assuage some of his guilt, I stop him immediately.

Larry discussed how he had resolved this dilemma for himself as a sex offender therapist. Sometimes he made the decision on his own not to report information that had been disclosed to him in treatment. He worked with men already incarcerated. His comments allude to the arbitrary line that separates his role as that of therapist from that of witness for the prosecution.

Dealing with Other People

Stolorow and Atwood (1992) in their work related to the effects of trauma on children describe how it is not necessarily the nature of the trauma itself that leads to later

difficulties. Instead they describe how failure to effectively integrate the trauma plays a pivotal role in how the individual will ultimately be affected. It is not simply the intensity of the experience, but failure of integration of the experience in some supportive system that comprises the effect. The effect of trauma must be seen within a relational context. Therapists who work with trauma require an on-going support system to deal with their intense reactions to the work (Herman, 1997). Herman adds that if the therapist is unable or unwilling to find others who support her work, she will eventually find her world narrowing. She even admonishes that if a therapist who works with trauma finds herself professionally or personally isolated in her work, she should discontinue the work until an adequate support system is secured.

The participants in this study described some difficulties they encounter accessing meaningful support. This difficulty begins with their reported sense that they needed to spare other people the details of their work. This was partly to protect others from the content and partly to protect themselves from other people's reactions. They described their experience of negative reactions of others to their work with sex offenders and to themselves personally.

The sex offender therapists in this study recognized the negative impact of secondary exposure to the traumatic content related to their work. This is clearly illustrated in their reports of a need to spare other people from exposure to the details of the work they did. This was especially true when those others were close such as family members. The participants did not want those close to them impacted by the material. This resulted in the sex offender therapist being cut off from the most potentially

accessible support people in their lives. Nelda described how she came not to discuss her work with friends.

> I remember that people knew what I did but never really wanted to talk about it. I never thought it was a lack of support. I thought of it as sanity on their part.

Of course the question, "So what do you do for a living?" is practically an inescapable occurrence in modern social life. The sex offender therapists in this study had so frequently found themselves in awkward situations attempting to delicately field this question that many of them had developed fairly ritualized responses. Curtis discussed the caution he felt he needed to take in social interactions he had with others in which his work might be the topic of discussion. Generally he expected a negative response.

> I used to say, 'I work in a prison with sexual offenders.' And you always got a reaction. It didn't matter, I mean they either went, 'Oh,' and that was the end of the conversation, or you got a great opinion about what ought to be done to sex offenders.

He elected to withdraw from interactions from others rather than engage in fruitless and heated debates about the need or utility of sex offender treatment.

Negative Reactions from Others

The participants were readily able to recall negative reactions from others when discussing their work. These negative reactions from others occurred in both formal professional settings and informal social settings. The negative reactions were aimed at sex offenders in general, at the idea of treatment for sex offenders, and even at the sex offender therapists themselves. Societal attitudes toward sex offenders profoundly

influence the therapist. After all, sex offender treatment is not free of the social and political arena (Robitscher, 1980). Nelda shared her thoughts about people's extremely negative reactions to sex offenders.

> That's a garbage can most people won't climb into. And so I mean my interest in these guys I found was very unusual and not anything that most other people shared. They just thought we ought to shoot them.

In discussions of their perceptions of public support for sex offender treatment, the sex offender therapists' comments were consistently negative. Sex offender therapists accept that the public is generally not supportive of the work they do. Robert Freeman-Longo (1997) has described how he has been shunned by the public and even by other mental health professionals for his twenty-eight years of work with sex offenders. According to Blanchard (2002) for its own comfort the public wants a response that distances it from the crime and returns suffering in kind. Sam described it this way.

> Society thinks, 'Why should sex offenders get free therapy?' There's a mindset that the needs of the victims need to be met before the needs of the perpetrators.

Finkelhor and Lewis (1988) described a dilemma that sex offender therapists face. On the one hand, the public clamors for harsh punishment of sex offenders; on the other, treatment providers insist that punishing sex offenders does little to protect the public. Many of the participants shared their thoughts about the lack of public support they perceived for sex offender treatment. These comments sometimes did allow for the fact that this lack of support might be based on incorrect assumptions about the nature of the work.

The final ignominy that sex offender therapists reported having to deal with was their sense that the public had very negative perceptions of them as well. The fact that they were sex offender therapists impugned them some way in the public's eye. Nelda provided an example of how even close friends contributed to this sense that as a sex offender therapist she was somehow objectionable herself. She told this story of when she felt this rejection most tangibly.

> I remember another therapist looked at me and said you know I know why I do what I do. But I don't know why you do what you do. I felt that at that moment, oh yeah, you've got the worthy client and I don't.

This incident was probably more painful because it came from professional peers that she might have hoped to have been more supportive or informed. Neal provided an illustration for how personally he is affected by this kind of perception of him.

> I'm now looked at as someone who is helping the population that a great many people don't believe can be helped or should be helped. And questioning, 'So what kinky secrets do you have in your closet that makes you want to help them?'

It is understandable that the public can be so averse to any displays of mercy or charity toward sex offenders. After all, these violent and abusive men have damaged the lives of many innocent people including children. The sex offender therapists who are primarily responsible for the treatment of sex offenders must somehow appreciate the level of emotion generated by the damage sexual abuse wreaks. They must still be able to remain objective in their response both to sex offenders and to the public's reaction to them as sex offender therapists.

Reasons for Being a Sex Offender Therapist

A therapist treating sex offenders must be skilled in a number of areas that are not common to other types of counseling. While all forms of therapy are demanding and sometimes draining, treating sex offenders is especially so. The process of frequent confrontations; being on guard against deception; challenging habitual, subtle thinking errors and distortions; and working with a largely nonempathic clientele is different from most other forms of treatment (O'Connell, *et al*., 1990). Sex offender therapists are advised to look carefully at themselves and at what they bring personally to the domain of sex offender treatment (Roundy & Horton, 1990). Therapists who work with sex offenders, like most people, are subject to a variety of pre-existing biases and personal issues about sexual deviancy. The domain of enquiry in this study that addressed some of these personal issues assessed the therapist's motivations for engaging in this line of work.

The reasons cited were both internal and external. There were five clearly identified reasons that were discussed by the participants for undertaking and continuing the work. The most common response was that the work was so interesting. Some of the participants described how the work contributed to their personal and professional growth. There were several responses that were related to meeting the needs of the community and preventing future sexual abuse.

Internal Reasons

The most salient answer to the question "Why do you do sex offender treatment?" surprised even the sex offender therapists themselves. Many of them reported that

initially there was a tangible motivation to contribute to the prevention of sexual abuse, but as time passed something else emerged. This more internal motivation that emerged was primarily curiosity and interest. Nelda described her change in motivation this way.

> It wasn't because I wanted to stop abuse anymore. That wouldn't have gotten me to do it for 20 years. You hate to tell somebody, I work with this despicable population because I find them interesting.

Sex offender therapists must possess an interest in the investigative nature of their work. There is a need for continual probing of contrary evidence. Information needs to be gathered, probed and placed in context. Rather than trust the offender as the sole source of information, other sources of information must be assessed, such as police reports and victim accounts. The therapist needs to be intrigued, rather than put off by the process of gathering all the data and seeking for deception or inconsistency. For the sex offender therapists in this study, sex offender treatment is incredibly interesting. It was interesting for different reasons for different sex offender therapists. Melvin, who had previously worked in mental heath for 15 years, reported that his work with sex offenders turned out to be the most interesting thing he had ever done. The important aspect of that interest was the challenge of figuring out the sex offender, of solving the intellectual puzzle. He described it this way.

> I liked that you basically had to be thinking. I loved the kind of cognitive aspect, the mental chess game we played in group. I was drawn to the challenge.

He commented on how he had been aware of the reputation of sex offenders not being amenable to treatment. He responded personally to this as a challenge. This was coupled with an interest in the dynamics of sexual deviancy itself. The challenge to

understand how treatment could impact this problem proved very stimulating for him. The interest was specific to the nature of sexual deviancy and human sexuality in general.

A closely related personally rewarding aspect of working with sex offenders that was discussed was the recognition by sex offender therapists that they were good at sex offender treatment. Kevin made these observations about himself as a sex offender therapist. He described how he became an even better therapist as a result of working with sex offenders. If you can do it with this group, the rest are cake walks.

The final internal reward that was identified was several accounts of personal growth. This personal growth was directly attributed to the work that the sex offender therapists had done with sex offenders in some way. Eve, like Kevin, reported that working with sex offenders had made her a better therapist generally. She added that the personal growth she experienced bridged outside of her professional life and reported very personal gains as well.

> Working with sex offenders has taught me that I'm capable of just about anything. They've taught me to be honest with myself even if I can't be honest with anyone else.

External Reasons

When queried as to what were some external reasons the sex offender therapists decided to work and continue to work with sex offenders, their answers fell into two categories; they were filling a need in their community, and they were preventing sexual abuse. Therapists who choose to treat sex offenders must be committed to treatment as

the best course of remedial action. Kevin replied that part of what motivates him to continue is that the work needs to be done and that the work mattered.

> If we're not gonna lock up a sex offender forever you know we should be treating them because it does decrease the chance of them re-offending.

According to Aponte and Winter (1987), the vehicle for change is the social relationship. It is the process of interpersonal relating that heals more effectively than any therapeutic task or goal. There is no data to suggest that sex offenders are an exception to this therapeutic rule. When the fundamentals of relationship building are not applied to sex offenders, little growth or movement will take place in counseling (Blanchard, 2002). Firm consequences and even incarceration are frequently necessary to control sexual offending behavior. A humane approach however, is an absolute necessity for the treatment of sex offenders, while a punitive setting serves only to perpetuate the violence of offenders who are sentenced to them (Gilligan, 1996). The participants in this study addressed how they were committed both to a firm and direct approach to sex offender treatment and at the same time to a compassionate response.

Compassion can be conveyed in a firm and critical tone while still being received as an expression of kindness and concern. Compassion can be seen in the therapist's consistent honesty with the offender even when he is tempted to do otherwise. Certainly it can be tempting for the therapist to engage in an excessively judgmental and punitive way towards the sex offender. Asking a therapist to show care to someone who has committed a violent sexual assault creates a difficult and demanding expectation. Still, establishing this kind of caring relationship early in treatment is crucial for a successful outcome (Malan, 1976). Neal discussed both helping the sex offender change and

protecting future victims. He is primarily interested in preventing further sexual assaults, but offers the caveat that helping the sex offender is a rewarding aspect of the work for him.

He had much to say about the dual motivation of helping the man and preventing future sexual assault. Clearly, helping the man to change is likely to serve positively in preventing future sexual assault. But Neal's comments alone among the sex offender therapists interviewed paid a special emphasis to the idea that treatment should focus heavily on the needs of the sex offender. He emphasized how these men are going to be out in the community. And that by treating them humanely he is ultimately serving the community, because the men unfortunately can do great harm.

> It's kind of a balancing act. I need to keep the community safe, and at the same time, I'm dealing with a human being in front of me that is more than just a sex offender, but a human being, and is someone that I want to help.

The main purpose of sex offender treatment is to prevent further victimization (Salter, 1988). This is a very different situation for therapists whose training and practice have generally prepared them to see their professional and ethical responsibility as being primarily to the individual and not foremost to the community. In effect, this involves the therapist as a key part of a system of behavioral control (Emory, Cole & Meyer, 1992). Eve used this metaphor to illustrate her position.

> People ask me why I work with offenders. And I say, it's like somebody is standing at the top of a cliff pushing people off the cliff. Sooner or later you have to climb up the cliff and stop the person that's pushing people off, instead of

catching people at the bottom. The only way to prevent a sexual offense is to work with the offenders themselves.

This work requires that the therapist make judgments about whether the sex offender is a good risk to be at large, to complete treatment, and so forth. If the therapist thinks the offender is at risk to re-offend, she reports that to the authorities, even when the sex offender does not agree with that assessment. The sex offender might find some aspects of treatment coercive and intrusive. If the primary concern is to prevent re-offense, then these kinds of intrusions are necessary and justified.

Effects of Doing Sex Offender Treatment

Sex offender therapists are susceptible to the identified stressors inherent in the general practice of psychotherapy (Sullivan, 1993). Research that examines the personal impact on clinicians who work with traumatic content focuses primarily on therapists who work with victims of trauma (Bloom, 1993; Grosch & Olsen, 1994). There are stressors unique to clinicians who regularly contend with primarily traumatic content (Black & Weinrich, 2000). Few studies have addressed the impact on clinicians who work with the perpetrators of sexual violence, and those are fairly recent (Farrenkopf, 1992; Steed & Bicknell, 2001). These early explorations have reported that the impact of working with sex offenders is very similar to that of working with the victims of trauma in general (Way, *et al*., 2004). Sex offender therapists have the demanding task of not only rehabilitating the offender, but an obligation to safeguard the welfare of others as well. Perhaps due to this expanded social responsibility, Scott (1989) has declared that

psychotherapy with criminals is the most demanding task in the entire area of mental health.

Unique to the role of the sex offender therapist is the need to repeatedly address and evaluate the disturbing thoughts and behaviors of sex offenders. To accomplish the goal of preventing future sexual assaults, the therapist must review the dynamics of past offenses. Details of violent sexual behavior and fantasies are a regular focus in sex offender treatment. The sex offender therapist is not immune from having to privately process this emotion-laden material. As a result, the sex offender therapist inevitably experiences strong emotional and cognitive responses to this sexually deviant and aggressive content (Kearns, 1995). Although this condition is only one of the stress provoking aspects of the work, the repeated exposure to this content can contribute considerably to vicarious traumatization (Edmunds, 1997).

Vicarious Traumatization

Vicarious traumatization was first described by McCann and Pearlman (1990). They noted the pervasive effects of doing trauma therapy on the identity, worldview, memory system, and psychological needs and beliefs, of the therapist. As a result of exposure to the realities of trauma in the world, the therapist is changed. *Vicarious traumatization is the transformation of the inner experience of the therapist that comes about as a result of empathic engagement with the clients' trauma material* (McCann & Pearlman, 1990). This includes being a helpless witness to past events and sometimes present reenactments. It is a process, not an event. It includes the therapist's reactions or feelings and defenses against those reactions.

The effects of working with the traumatic content inherent in sex offender treatment can be conceptualized as secondary trauma. According to Figley (1995), secondary trauma is a syndrome of symptoms nearly identical to PTSD except that exposure to knowledge about a traumatizing event is the catalyst. While the symptoms of secondary trauma are consistent with those of PTSD, they are expected to manifest at a sub-threshold level. The effect of repeated exposure to other people's traumatic material is conjectured to have a cumulative effect on the therapist (Cornille & Meyers, 1999). Kassam-Adams (1999) has reported PTSD symptoms at clinically significant levels in at least 40% of those therapists who work with substantial numbers of traumatized clients. The final two sections of this analysis will explore the reactions of sex offender therapists to the work and their defenses against those reactions.

The DSM-IV-TR (2000) includes four criteria for a diagnosis of PTSD. Criterion A is exposure to a traumatic event. It includes exposure to the knowledge of traumatic events that have occurred to significant others. Criteria B are the re-experiencing symptoms. These include intrusive recollections, dreams, and distress at exposure to reminders. Criteria C are the avoidance symptoms. These include avoiding any reminders of the trauma (conversations, thoughts, people), alienation from others, loss of interest in activities, restricted affect, and pessimism about the future. The majority of distressing reactions that were described in this study resembled criteria C. Criteria D are the arousal symptoms. These include irritableness, hypervigilance and sleeping problems. Many of the symptoms in all these criteria are consistent with the reports provided by the participants in this study. The analysis that follows will illustrate these consistencies.

The first criterion, exposure to an extreme stressor has been addressed throughout the first section of this analysis. The qualifying traumatic experience includes witnessing or learning about the actual or threatened death, injury or threat to the personal integrity of a close associate. Events experienced by others that are learned about include violent personal assault. The person's response must involve intense fear helplessness or horror. These responses may be more severe when the stressor is of human design (APA, 2000). The severity, duration and proximity of an individual's exposure to the stressor are the most important factors affecting the likelihood of developing the disorder. The recurring and repetitive nature of exposure to traumatic content by trauma therapists is reported to exacerbate the symptoms of secondary trauma (Figley, 1995).

Re-Experiencing

The second group of criteria contains the re-experiencing symptoms. Only one of these symptoms must be present for the diagnosis of PTSD. The traumatic event can be re-experienced in various ways. Commonly the person has recurrent and intrusive recollections of the event. The participants in this study did not report abundantly on reactions to their work that were consistent with this group of symptoms. Kyle described some difficulty he had with intrusive memories.

> A lot of times when I'm around kids, like when they're yelling and playing and stuff. It just jumps in there. Really bad accounts I've heard, and re-enactments that were brutal.

Carla describes this incident as the worst reaction she has ever had in her work with sex offenders. She describes the difficulty she encountered in her attempts to get over it.

> Watching a re-enactment with a male child, I made the mistake of thinking, oh my god, this could be my son. I didn't think I could stand it. That was the worst experience. It took me forever to get over that. I couldn't stop thinking about it. It affected me so deeply that I couldn't talk about it. I saw him. I saw it.

Re-experiencing can manifest as recurrent or distressing dreams during which the event can be replayed or otherwise represented. Carrie described these dreams and how unsettling they were for her.

> I remember having dreams where I was offending someone sexually in my dream and I'd go to work the next day like, "I have got to take a vacation. I've got to get away from this.

Kyle reported how he began to recognize that the content of his dreams was becoming similar to specific descriptions of sexual assaults he had heard in his group work. He stated that the emergence of these themes in his dreams was gradual but eventually became very graphic and disturbing.

> I had never had any really bad nightmares in my life, especially nothing that had ever woken me up. These things were awful. It was me doing it. I was choking people and beating them…kids! I was doing it to kids! It got to where I couldn't sleep for the longest time.

In rare instances of PTSD, the person experiences dissociative states that last from a few seconds to several hours (Herman, 1997). During these states, components of the

event are relived and the person reacts as though they are experiencing the trauma in the moment. Some of the sex offender therapists described how visualizing the content disclosed was a problem for them. The problem was not that they could visualize. The problem was that it happened when they did not want it to. The participants reported intrusive mental images that prompted strong emotional reactions from them. These mental images were reported in slightly different forms. Neal used the term "being in the moment" to describe occasions when the sexual assault description became so real that he seemingly experienced it in the moment. He described his reaction on one occasion when this happened to him.

> Suddenly, you were just plastered against the wall. It was almost like we trying to push through the wall, trying to put some distance from the scene. I had to get away from it.

Kevin described how he responded to the more tangible descriptions of sexual assaults that occurred during re-enactments.

> You got some real graphic depictions of some of the crimes, and I actually was very disturbed by that for several days after.

These episodes are typically brief, but can be associated with prolonged distress and heightened arousal. Eve describes a more specific form of this tangible visualization. For her those incidents of "seeing the child," the victim of the sexual assault, represented the most disturbing incidents she encountered as a sex offender therapist. She described one particularly negative experience.

> It was just, it was so horrific, it felt real, it felt like I could hear that child, and it greatly moved from the theoretical to the emotional. We had men who literally disassociated in group.

Intense psychological distress and physiological reactivity are the final two re-experiencing symptoms. These often occur when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event. In the case of re-enactments, that part of the treatment process in which the offender re-enacts the sexual assault, it is difficult to say whether the exercise is a trigger or itself a traumatic event. The effect of this experience of "seeing the child" is compounded for the clinician if the child described is in any way similar to their own child. Melvin gave this account of his physiological reaction to such an experience.

> I couldn't help but think about my daughter. It would create a visceral reaction in me literally. My gut would always get well, sick.

Intense psychological distress or physiological reactivity often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (APA, 2000). The closest thing to a physiological response reported by this group of therapists was disgust. This was the most frequently reported reaction to sex offenders overall in this study. Kevin makes the distinction that it is what the sex offender discloses or his behaviors that prompted his reaction. His reaction is to the content and not to the sex offender.

> You just get sick of hearing those words over and over… penis…sodomize…anal.

Carrie described how she recognized a physiological reaction to the presence of one man in particular that was very different. Her initial response alluded to the content he disclosed, but her reaction is distinctly to the sex offender himself.

> There was one guy that came in once that just had a presence about him that just made you want to cringe and move to the back, like you just wanted to take a bath after he left, you just felt dirty. I just felt like there was something evil about this man.

It is difficult to contemplate what Carrie could do with such a present and potent negative reaction to a client she is attempting to engage therapeutically. She herself responds to the dilemma illustrated here when she reports.

> I don't know what I did with my disgust. I kind of just tried to let it go.

Avoidance

The majority of the described effects from working with sex offenders were not the re-experiencing symptoms in criteria A. Instead, most of the descriptions provided were more consistent with the avoidance symptoms in criteria B. Pearlman and Saakvitne (1995) discuss how in their conceptualization of vicarious traumatization, avoidance symptoms are adaptive strategies that were initially developed to manage disruptive feelings and thoughts. This tenet is central to current trauma theories (Herman, 1997). The traumatic event is proposed to overwhelm the individual's perceived ability to cope (McCann & Pearlman, 1990). Avoidance as an adaptation is an effective response to diminish the impact of exposure to traumatic content but may prove deleterious if over-applied. Avoidance strategies may not serve the best interests of the therapist in a non-

trauma context. These avoidance behaviors can become entrenched and resistant to change. Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid conversations, thoughts, and feelings about the traumatic event.

Conversations

The manner in which sex offender therapists avoided talking about sexual deviancy and issues related to work was very formalized. It involved keeping others from even knowing they were sex offender therapists. Carla described that she tries to keep from even entering into these kinds of conversations.

> I anticipate a negative reaction. I get one of two reactions. One is oh my god, why do you do that? How could you? The other is, oh that is so interesting. And they'll start a conversation. And that's all they want to talk about. Then I have to get out of those things.

Mark described how he had developed a patterned response to questions about his work. He described an elaborate maze that he forced others to navigate in order to find out what it was he did for a living. He asserted that the purpose of the maze was not to conceal the fact that he worked with sex offenders, but to keep from having to get into conversations about sex offenders.

> I've got other conversations I want to have rather than being at a social gathering and having to sit there because you know then you always get into, "Wow, how come these guys do this? I mean, why on earth?"

Thoughts

The sex offender therapist's described three important strategies they used as a way to manage their thoughts while working with sex offenders. These were cognitive processes employed to regulate or temper their reaction to the experiences or content they were exposed to in their work. They included personalizing, compartmentalizing and filtering details. They were specifically employed in response to exposure to traumatic content related to the process of sex offender treatment. Some of these measures look very much like reactions to the traumatic content as well as managing strategies. These reactions are volitional and employed by the sex offender therapist to remediate the effect of the content they are exposed to. The distinction may be somewhat arbitrary at times as to whether the response is volitional and conscious or primitive and unconscious. In their descriptions the therapists proclaimed that they employed these measures volitionally. A very clear cut admonition that I heard from several of the sex offender therapists was not to take things personally, not to personalize. Carla said this.

> I never make anything personal. You've got to find a way to separate yourself, your personal life, your family, from what you hear, what you do.

Nelda recounted an incident early in her career which helped her see the importance of not becoming over-personally involved in her work as a sex offender therapist. In the incident, she was attempting to influence the victim-daughter of the importance of recommending to the judge that the father needed to be incarcerated. The daughter wanted her father to be ordered to treatment instead. She confronted Nelda for trying to assert her own will into the situation. This admonition coming from a child to not be so personally involved has resonated with Nelda ever since.

> It wasn't about me. And my sense of outrage, just didn't have a place. She was saying, 'I don't hate my dad and I don't need you hating him for me.'

She described the technique of not personalizing with much more emphasis in the following excerpt. Working as a sex offender therapist for over 25 years, she has trained many people in the field. She described the technique of not personalizing as a critical part of remaining objective with sex offenders. She had repeatedly witnessed the negative impact on clinicians to the content they were exposed to in the work. One of the more negative situations she had seen were those incidents in which the clinician imagined how they would feel if their own child were victimized.

> It can never be your child it can never be that personal. If you see this man as doing that to your child, I don't know how you can ever work with him. I couldn't work with someone who did that to my child.

She describes the problem of over-personalizing in terms of counter-transference. For her, issues of counter-transference are never good with sex offenders. She does not describe how she manages her own counter-transference. Her description sounded as if she has avoided counter-transference feelings altogether, or at least minimalized them to a point where they are not distressing. Dahlenberg (2000) asserts that avoiding counter-transference reactions can negatively impact treatment. Nelda's position appears to be that not avoiding these reactions has a negative impact as well.

There is some evidence that sex offender therapists with a personal history of sexual abuse do report higher levels of vicarious traumatization (Bride, 2004; Crabtree, 2002; Way, *et al.*, 2004)). Larry reported how his ability to not personalize his reaction to the content he hears is directly related to aspects of his personal life.

> I think the key to doing this work well is that I've never perpetrated sexual abuse and I've never been a victim of sexual abuse, and I think those two things are critical.

Finally, Nelda provided an illustration of how she is able to engage in the work fully and in an emotional capacity without bridging over into having too personal a reaction to the content. She reported how she was able to still experience the traumatic descriptions emotionally but not personally.

> I felt like I'm sort of a receiver you know like a radio. I don't make the music, I'm not responsible for the music. Um I relay it in a way that's useful to this person. I feel that fear and loneliness, but it's not mine.

Compartmentalizing

The next technique has a contradiction inherent in it. The technique described is compartmentalization. Compartmentalizing is the process of dividing external objects into either all good or all bad categories (Freud, 1946), The contradiction is that the sex offender therapist is admonished not to compartmentalize at one moment and assured of the necessity of compartmentalizing at another. There were several accounts given where compartmentalizing helped the sex offender therapist at least to continue to work effectively with sex offenders. Melvin said this.

> Perhaps it's just through compartmentalization. I just don't dwell on that part of them and their behavior in general. You have to be cognizant of their behavior because that's what you're treating.

The difficulty with compartmentalizing is maintaining a balance between the two aspects of the sex offender that the therapist deals with. On the one hand, the client is a human being and deserving of compassion. On the other hand he has committed horrific offenses and is a danger to the community. Roundy and Horton (1990) warn that the sex offender therapist needs to attend closely to her counter-transference toward the sex offender. Separating the man from his behavior offered one way the clinician was able to attend to both the traumatic content and the human being at the same time. Sam said this.

> I split the person. I have one identity of him as a ten-year-old victim and another as a seventeen year old offender that should never be let out of prison.

Responding to the offender as a ten-year-old victim could lead the therapist to enact a need to rescue and be drawn into a protective and nurturing stance toward the man's treatment. Responding to the sex offender as only a perpetrator could lead to clinical abuse. The therapist might tend to misuse treatment as a vehicle for administering justice. Carla reported on the difficulty of this proposition.

> I've been doing it for ten years. One of the biggest difficulties is being able to separate the person from their behavior.

These are examples of separating the sex offender as a man from the sexually deviant behaviors he perpetrated. Kevin described this technique as well. He addressed how compartmentalizing his negative reactions to the sex offender helped him to work effectively with him.

> If I've got any ability at all, it's the ability to separate people from their behaviors. I'm able to compartmentalize that anger that I had for him and function with him and interact with him at work.

Kevin does offer some cautionary information related to compartmentalizing. As with other adaptive responses that serve well when initially employed, it appears that compartmentalizing may have unforeseen negative consequences when employed in other settings or over the long term.

> When you compartmentalize something long enough you don't really know how it affects you in other ways. I don't know if it's served me well, but it did serve me in getting through with minimal pain. I may have definitely had some negatives because of that process.

Not compartmentalizing refers to maintaining an image of the sex offender as a whole person and not focusing solely on his sexually deviant behaviors when working with him. This technique appears to have been important in helping the sex offender therapists to retain some positive regard for the sex offender in light of sometimes horrific behavior. Nelda's admonishment not to compartmentalize suggests a deeper understanding of herself that has emerged from her work with sex offenders.

> I think when you're able to say, one human being is despicable it's not a Grand Canyon leap to finding others that way. And it diminishes your capacity to care for human beings in general.

She states that the ability to summarily reject people that completely, even sex offenders, will generalize to ones way of connecting to other people as well. Sex offenders use this approach to people when they victimize. She admonishes that anyone can be this way if they don't actively counter these tendencies.

Neal provided this account of how important it is for him to be able to see the sex offenders he works with in this more balanced perspective. It was important for him to

not just see sex offenders as monsters. But it was still important for him to stay cognizant of the harmful behaviors they were capable of. He described how difficult it was for him to hold both of these apparently disparate views of the man at the same time. He warned that if the clinician does not retain both views then his work with offenders is impaired.

> It really does force one to step back and say, can I really be invested in this individual as a person and human being.

Filtering

McCann and Pearlman (1992) hypothesized that all therapists working with traumatic content will experience a lasting impact on their lives. While the content of the exposure is one determinant of this effect, the level to which the therapist perceives the content is another relevant component. Another very effective strategy employed by sex offender therapists to mediate their reaction to the content they are exposed to is to selectively filter out those portions that impact them most negatively. Disclosures of traumatic content force the therapist to enter and accept worlds that they have before been able to hold at an intellectual distance (Dalenberg, 2000). Sam described this procedure metaphorically like this.

> It was hard to accept it as reality. It seemed more like watching it on T.V. It was a defensive mechanism to keep it from sinking in. I didn't want to hear it.

Curtis doesn't actually report that he is filtering out the details, but the sense in his report is that there is some part of the content he is hearing that is not being as fully processed.

> I intellectualize the experience in that sense and have become kind of desensitized to the actual sexual aspect of it. I never really allowed myself to think, boy this is real.

The therapist is called upon to tolerate the story and attendant emotions while remaining psychologically available to facilitate the treatment agenda. Filtering out the more abhorrent details was a viable method used to remain present with the sex offender during the treatment process. Steed and Downing (1998) have reported that this self-protective response in which the therapist actively filters out part of the content they are exposed to can become habitual and automatic. Carrie adds that the details are not really a critical part of the work for her. The sex offender may need to report or confess the details to her, but they are not necessarily the critical part of her continuing work with him.

> There's a lot underneath what they say. Part of my job is to help them get underneath. It was more getting underneath to the emotional stuff and the process, not the details.

Avoiding Reminders

Another type of avoidance is when the person stays away from activities, situations or people that arouse recollections of the traumatic content. This is a protective behavior that is consistent among people who struggle with PTSD (Herman, 1997). Kolb (1984) describes this withdrawal as a defensive strategy to reduce the activation of emotional responses to stimuli in ones environment. Two of the sex offender therapists

talked about the importance of avoiding things that remind them of work. Eve described having to change her entertainment habits.

> If I work in a situation where it's so heavy all the time, I don't want my entertainment to be heavy stuff. That's not entertainment for me. I didn't want to see it on the news. I still don't watch the news. It's almost a compassion fatigue. I don't want to see it anymore.

She added that she censored her discussions with people in order to keep them from finding out what kind of work she did. This censoring was not just an attempt to spare herself the potential rejection from others as was addressed previously. She had already accepted that people took exception to her work. She had learned to expect it. What she is describing here is avoiding talking about the subject-matter altogether.

> I got to where I just told people who asked that I was a counselor. Before, I had stopped because of the reaction I got from other people, but then, you just get tired of talking about it.

Mark described this same sentiment.

> When I'm not here, I don't want to talk about it. I don't get off to being in settings and talking about sex offenders. Yeah I mean it's not because I don't want people to know I work with sex offenders because they're going to think bad about me or whatever. It really is because there are other conversations I want to have.

Avoiding Taking It Home

The sex offender therapists discussed many protective measures they have developed for healthy self-care outside of work. Like most professions, it is inevitable

that the work one does will affect the person both while at work and while away from work. Sex offender treatment is no different in that respect, but it does have some differences which call for unique responses from sex offender therapists.

The most common response in this area given by this group of sex offender therapists was the injunction to "not take it home." Unfortunately, like any other job, parts of "it" came home anyway. Still it was a very important strategy for sex offender therapists to deliberately attempt to not take it home. Carrie talked about how she first began noticing that it was coming home with her in disturbing ways.

> I know I took it home. My husband would say, "Abuse, abuse, abuse! That's all we ever hear about around here. I don't want to hear this."

Kevin provided a specific illustration of how important it was to keep his home life and work life separate. In his example he describes how his awareness of sexual deviancy issues was beginning to have a contamination effect on his own sexuality. This is an experience reported in other studies of clinicians who work with sex offenders (Bengis, 1997; Edmunds, 1997).

> If you're going to go home that night and make love to your wife you have to compartmentalize that attitude that you have at work to some degree so that you can have intimate interactions.

Immersion in the field of sexual deviancy treatment creates a hypervigilance to sexual themes for treatment providers (Bengis, 1997). Many people experience sexual fantasies that can verge upon themes of abuse. It is probably more disconcerting when the person spends their day admonishing sex offenders for deviant thoughts for them to have even remotely similar thoughts. Larry added his emphasis to this topic.

> I don't replay things in my head. I've learned to not carry it over into my personal life. Learning how to shut that off early I think is one of the most important things that I learned to do.

Nelda gave a thorough description that includes the pitfalls of taking it home and some of the rationalizations she uses to leave work at work. In her descriptions of the work it is important that she engage emotionally with what is happening. She spoke of being the victim's voice in the treatment process. This is a potentially dramatic role to play when interacting with the offender. She has to maintain a balance between having an intense emotional experience and still not being too personally affected by it.

> I get emotionally upset in the moment for their victim. But it's not like I took it home and was disturbed by it very often. I remember when somebody killed their victim. That was disturbing. I took that home. I think that's what causes burnout.

She concluded with a reminder of the importance of processing or debriefing the content at work with colleagues as a specific antidote to the content lingering with her at home.

The final solution for sex offender therapists to employ in order to reduce the impact of exposure to the traumatic content through avoidance is to quit the job entirely, to leave the field. The cost of direct exposure to the suffering of others is high and it is impossible to know how many have chosen to abandon the field because the price was too high for them (Figley, 2002). Carrie left after several years, but indicated that maybe she should have left sooner.

> I really stayed there at the prison longer than what I…I believe was good for me…five years. I was there a couple of years too long.

She continues to work with sex offenders, but no longer in the prison setting. She now has a much more diverse caseload that includes working with general population clients. Kevin reported a similar conclusion he had reached about changing his work focus.

> When I left the sex offender treatment program, getting out of the job was more of a factor than most of the jobs I've left.

Diversifying caseloads to include working with non-trauma clients is recommended as a strategy to lessen the effects of vicarious traumatization (Perry, 2003). Carrie and Kevin both continue to work with sex offenders, but no longer in the prison setting. They are both no longer working only with sex offenders.

Avoiding Feelings

The avoidance of reminders may include amnesia or a diminished ability to recall important aspects of the traumatic event. The DSM-IV-TR (2000) uses the terms psychic numbing and emotional anesthesia that can begin soon after the traumatic event. These are states of diminished responsiveness to the external world. Figley (1995) uses the term compassion fatigue and suggests that like other kinds of fatigue, it can diminish the individual's capacity or interest in bearing the suffering of others. Empathic identification with others is frequently one of the reasons that people choose the mental health profession in the first place. Figley (1995) suggests that mental health professionals with a strong empathic identification with others are more susceptible to the corrosive effects of compassion fatigue. The more someone identifies with the suffering of others, the

more she is contaminated by exposure to it. Eve is the only sex offender therapist that used any of the terms related directly to vicarious traumatization. She stated.

> It's really kind of a compassion fatigue deal. When I was working at the program and the Murrah bombing happened, I really found myself being reasonably critical of the way the media was handling it. I think my level of compassion fatigue was higher because of working with sexual offenders.

Eve described a need to distance herself from the pain of others and how she recognized the reduced impact that other people's pain was beginning to have on her. She described feeling disturbed that she was becoming less bothered by the pain of others than she formerly had been. This reduced ability to feel emotions is specifically cited as one of the avoidance criteria in the diagnosis of PTSD (APA, 2000). The therapists reported a specific reduction in their responsiveness. Curtis described how he reacts in a seemingly non-emotional way to traumatic content.

> I don't know that I'm ever quote grossed out. I mean there's been a number of things that you'd hear guys talk about that you just go yeah, I don't understand how people could do that but they do it. And I don't need to understand.

He reported that in his fifteen years of working with sex offenders, he has never had strong emotional reactions to the content he hears in treatment. It is difficult to say whether his reactions were actually minimal from the start or whether his report is the product of a cumulative compassion fatigue. Mark provided this description of his cumulative decreased emotional reactions.

> While it certainly is distasteful, that really hasn't been an issue for me in a long time. I find what these guys do as distasteful obviously, but it's not something I feel anymore.

Neal described his experience of compassion fatigue in more cumulative terms. His was not a reaction to any specific incident.

> I eventually got to the point that I was so weary with hearing about suffering and all those things, just pretty weary of it.

Larry gives some indication of why he was perhaps able to work less affected by the content than others might have been. His report suggests that he may have accumulated some compassion fatigue before even beginning his work with sex offenders.

> I'd been working with veterans for four years and so hearing pretty graphic, aggressive, angry, violent, sadistic stories was not particularly unusual. I sort of was desensitized to it.

Turning Off Emotions

The therapists deliberately attempted to restrict their feelings. Emotional numbing is regarded as a defensive process that serves to protect the individual from becoming overwhelmed (Horowitz, 1974). This strategy was qualified as necessary to being effective as a sex offender therapist. A place for working through the objective content had to be created in which the meaning of the event could be processed free from the intrusion of distracting or even debilitating emotional reactions.

Carrie describes the paradox of how her goal is to attend closely to the sex offenders underlying emotions related to the sexual offense, but avoid or even inhibit her own level of emotional response.

> I wanted to help them explore what were the feelings that they experienced when they offended, and how do you share and work through those feelings. The details of exactly what happened, and how that affects me, that's not why we're here

Turning off their emotions was a protective strategy that sex offender therapists reported using. Their own emotional reactions are presented as having the potential to impair their ability to deliver effective treatment. Sex offender therapists take measures not to have emotional experiences themselves. The vicarious traumatization model conceptualizes this ability to control ones emotional responsiveness to stimuli as an issue related to power schemas. Over-control strategies, which include constricted affect or avoidance of emotions associated with vulnerability are developed to protect the individual's power schema from discrepant input (McCann *et al*., 1988). Larry described it like this.

> I don't do things where I feel like my emotional response, counter-transference if you will, is getting involved in the situation. I've got to be able to stay out of that.

McCann and Pearlman (1990) argue that the intense emotional reactions that result from exposure to traumatic client material may create emotional distress in the therapist. This distress may interfere with effective functioning in the therapeutic role. Carla reported how having emotional reactions while doing the work did interfere with her effectiveness as a sex offender therapist.

> That disgust interferes with being able to do treatment, because we don't want to make decisions based on that disgust.

Neal commented on how turning off his emotions was something he did actively.

> I had to get away mentally, to distance myself from the emotion.

Curtis described it more in terms of something that he gradually became aware of as something that was either happening to him or that he just gradually developed into.

> After a number of years of sitting in group and hearing this stuff, they start all sounding the same. You get desensitized to it I believe. You know, penis vagina, so what. Those are just words.

Eve discussed the necessity of turning off her emotional responses in order to be a more effective sex offender therapist. She like Carrie above followed this with a comment on the incongruity of being a therapist who does not respond emotionally to descriptions of sexual victimization. The parallel she draws between herself as a clinician employing this as a technique and the client employing it as a sex offender is somewhat unsettling.

> As the therapist, you cannot show the emotion. Being able to turn off the emotion contributed to my effectiveness. I would teach them not to intellectualize so much, and I needed to do it more to be effective with them…in order to teach them not to do it.

She described a shift she noticed in herself when she transferred to another agency. At this location, her contact with sex offenders reduced dramatically. She found it difficult to make the shift to turning her emotional responsiveness back on.

I don't watch my emotions so closely now. We teach the guys not to intellectualize. But I think that that's one defense mechanism I used a lot and still do.

The potential long term and cumulative results of limiting ones responsiveness to the external world is a progressive withdrawal from the world. While this withdrawal may be highly specific initially, as in the case of avoiding traumatic content, specific adaptations can generalize to other areas. The DSM-IV-TR (2000) criteria for PTSD describes how an adaptive withdrawal can generalize to other areas of ones life and become problematic. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities, or of feeling detached or estranged from other people.

Alienation

The participants in this study described their loss of interest in others and a sense of alienation. Part of this sense of estrangement was a product of not being able to talk to others about the work or the impact it was having on them. The negative reactions they expected and received from others also contributed. They described how feeling conflicted themselves about aspects of the work contributed to their sense of alienation as well. Some of the participants discussed impressions that the content had even contaminated their own sense of sexuality. This further compounded their looming sense of isolation. And for many of the participants there was a clear resultant sense of seeing themselves differently in time and generally feeling cynical about others as well.

A sense of alienation, as it is described in the vicarious traumatization literature, can be a product of working with the traumatic content disclosed by sex offenders (Bengis, 1997). Carla described this feeling in general terms when she said.

I feel pretty isolated as a professional.

Studies that have investigated the career dissatisfactions of therapists have reported consistently similar themes (Kilberg, *et al.*, 1986). A common theme is isolation. It includes therapists' feelings of separation from professional colleagues, and of social distance stemming from the difficulties of explaining clinical work to friends (Farber, 1983). Several of the other sex offender therapists described a reticence to discuss their work in public settings. This reticence was mostly due to concerns about the negative responses they expected from others. Curtis described in very introspective terms his sense of alienation from others as a result of his work. He described specific interpersonal changes that had occurred in himself as a result of the kind of work that he had done with sex offenders.

> It affects our relationships with other people because you can get a really clear sense in terms of when someone is trying to screw with you or play a game with you.

The change in himself that he describes here is that he has developed a working awareness of the darker aspects of humanity. He has an enhanced ability to use that awareness in his interactions with others. He refers to it as a vast resource of experience and information in terms of interpersonal reaction. He describes this ability in terms of power over the interaction. The effect on the other person of his using that power seems to be that others retreat from him.

> No one can get control of the relationship with you if you don't want them to have that. You can take them to a place that they don't want to go. You will know more about them in a moment and have them questioning who they are. So, they'll want to quit with you or with me in that context. When you have the ability to do that it's important that if people see that side of you that you make sure that they get to see an awful lot of the other side. So that they can balance that out. Because if they can't see that, then I think they can become fearful, and they won't understand….that we're human beings.

He goes on to describe interpersonal measures he believes he must take when interacting with people to counteract the changes that have been wrought in him. He states that he has to actively augment the kind of person he now is interpersonally with some careful balancing material in order to keep people from distancing from him.

Contamination

Many of the sex offender therapists reported a surprising awareness of how their job was affecting them outside of work. These descriptions were presented as a contamination effect that was not present before working with sex offenders. Bengis (1997) asserts that clinicians who work with sex offenders will become aware of a host of new ideas and feelings as a result of their work. Some of these changes include: 1) mistrusting others' sexual behavior; 2) confusion about their own sexuality; 3) anger, rage or distress about the levels of sexual abuse in the world at large; and 4) cynicism about people in general. Some of these observations occurred very soon after beginning the work. Larry stated.

I found myself being distant from kids for no other reason than because of the things I had heard in working with offenders.

The isolation and silence about how the work might be affecting the clinician only contributes more to a sense of strangeness that emerges from exposure to sexually deviant and traumatic content. Clinicians cannot listen repeatedly to the descriptions of sexually abusive acts without experiencing intense and confusing thoughts and feelings (Bengis, 1997). Carrie described a conversation she had with a colleague that related to the contamination effect of working with sex offenders.

Sometimes I wondered if I was perverted too.

Larry noted this effect.

I thought I knew what normal sexuality was and then I started working with these men and I'm hearing a lot of things that I don't know where the line actually is. I came out real muddled about what's normal, what's deviant, and it's affected me personally. I just chunked everything. I thought asexual is what I'd better be just to be safe. And I had to sort through it all.

Sex offender therapists may become disturbed the first time they acknowledge to themselves that exposure to descriptions of sexual deviancy has aroused them (Bengis, 1997). Often self recrimination and questioning follow the experience. This issue came up repeatedly. Sam described how he recognized an effect the work was having on his feelings about his own sexuality.

I remember early on having the experience of being aroused by one of the stories. You have to deal with what's wrong with me that I would get aroused? Am I

weird? Or does that somehow make what they did okay? Where's the line between deviant and normal?

Once asked, these questions are not easily answered. The psychological health of the sex offender therapist is best served by coming to grips with the answers. In one study of sex offender therapists, 45% of the respondents acknowledged having private concerns about their own personal sexual behavior (Ellerby, Gutkin, Smith & Atkinson, 1993). Carla described this effect in very personal terms. She even noted that her faltering attempts to deal with this issue contributed to undermining a relationship she was in at the time.

> When I first came here, I thought Geez!...I became less sexual and paranoid. It was really confusing for me for a while to stop and say one thing's normal and one's not. It really messed me up.

In her survey, Edmunds (1997) reported that 31% of sex offender therapists admitted to some degree of loss of sexual interest since beginning work in the field. Kevin believed that this effect had a negative impact on a relationship he was involved in when he first started working with sex offenders. But the effect did not end there. He spoke specifically about how the work he was doing led to questioning many of his beliefs about his own sexuality and how this exploration manifested in his subsequent relationships.

> I think you start censoring your own behavior, to some degree because you know... you've developed a pattern and a habit of censoring other people's sexual behavior, and I think it's hard to turn that off. We all objectify, to some degree. I

think about why, you know some of my behaviors that are very similar to some of their behaviors, why my behaviors aren't wrong.

For Kevin, the worst thing a sex offender therapist could do would be to equate their own behaviors with those of the sex offender. The only distinction between himself and the offender that he was able to have confidence in was that he hadn't sexually victimized anyone, and the sex offender had. This was not an especially comforting distinction for him. In this instance, Kevin makes some fairly confident connections between how what he is exposed to at work affects this aspect of his personal life. Later he was less clear about such residual effects of the work.

> I still have to sort out from time to time how it did affect me. It's real hard listening to something day in and day out....for it not to have some kind of negative effect or impact on you. I really don't know exactly how that job affected any of that. And I'm not sure that I ever will.

This lack of clarity as to what the long term or residual effects are was reported by other sex offender therapists as well. Eve stated.

> Five years later, the work still has an effect on me.

The effects of vicarious traumatization upon sex offender therapists are still not well understood (Steed & Bicknell, 2001. There are consistent indications that secondary exposure to traumatic content can disturb the clinician's ability to engage intimately with partners (Trippany, *et al*., 2004). Sexuality is a difficult issue for most people to address interpersonally under the best of conditions. It is unfortunate that even clinicians who are professionally trained to deal objectively with these issues are limited in their ability to address them.

Cynicism

Another type of response related to feelings of alienation that emerged had to do with the way sex offender therapists eventually began to see themselves differently. The descriptions provided here suggest a self perception that is not typical of most people. It is unclear from these examples whether this group of sex offender therapists saw themselves in this light before their work with sex offenders or whether it came afterward. It appears to be a form of self perception that could be relevant specifically to the kind of work a sex offender therapist does. Curtis described himself like this.

> I'm a person who is able hold other people accountable and be directive with them. Some people can't because they have some personal issues or needs about being nice, and socialized and liked or accepted.

His description of himself implies that he is not a person who has strong needs to be liked or nice. It appears that this description does not just apply to his professional role, but that it is more general. Nelda described herself this way.

> It's never anything I've backed away from its sort of no matter how awful or shocking or terrible it is I mean I will just step into it. I just go there.

Again, this is appears to be a general description of who she is as a person and not specifically limited to how she operates as a sex offender therapist.

Related to this altered sense of self, Carrie described a change in how she viewed others as well. What she calls skepticism began with the realization that many of the therapeutic gains she thought the sex offenders were making were based on their deceiving her.

> I had become very skeptical of anything anyone told me. I had become very cynical about whatever was said. It made me question what was the point of what I was doing. Was I really helping anyone, and how would I ever know?

She then described concerns that her skepticism about sex offenders was generalizing to people in general.

> I think your going to have to have some degree of cynicalness, yes. But not so cynical that you don't believe anything anybody tells you.

This *cynicalness* about people in general relates directly to a central issue in vicarious traumatization. Pearlman and Saakvitne (1995) describe how vicarious traumatization can disrupt the therapist's trust and dependency schema. The ability to count on others to meet one's emotional, psychological or physical needs becomes impaired. The experience of betrayal is part of the trauma and is integrated into the therapist's expectations of others in the world. Nelda described how her cynicism had generalized to others, including those closest to her.

> I'm not sure that you're not a threat. I don't know that my husbands not a threat. You can not see in the heart and mind and soul of somebody. I mean that's just arrogance that I can look at you and I can tell.

Some of the comments related to loss of interest in other activities or feelings of estrangement from the world described measures the therapists employed to counteract these effects. These consisted of activities sex offender therapists engaged in as an effort to stay connected to the larger community in general.

Larry was unique among these sex offender therapists in that he was able to share his work issues carefully, but effectively with his wife.

> My wife…her validation of my skill at working with these men is very important and I respect her opinion.

Nelda summed up the importance of remaining connected to the larger world with an apt analogy.

> Well I remember when I was going to school one of my professors once told me if you're going to be a lightning rod, be well grounded. If you're going to sort of attract this energy you need to be well grounded in yourself and your life.

Pessimism

The final avoidance criterion is a sense of a foreshortened future. This includes entertaining pessimistic career expectations (APA, 2000). The closest indicators of this were presented as reduced expectations for the efficacy of sex offender treatment that emerged as a result of working with sex offenders. Concerns over the efficacy of psychotherapeutic treatment, the lack of research validated procedures, and the difficulty in evaluating treatment results have been reported to contribute highly to career dissatisfaction for therapists in general (Farber, 1983). How effective do sex offender therapists believe sex offender treatment is in preventing future sexual abuse? Comments by the therapist in this study were not enthusiastic. Those sex offender therapists who affirmed the effectiveness of sex offender treatment did so rather cautiously, such as Kevin who qualified his report on sex offender treatment effectiveness.

> I just don't think even a 24-hour program reinforcing the appropriate is going to be as reinforcing to them as that physical and sexual stimulation.

The problem of changing the nature of a sex offender's deviant arousal pattern was a critical issue for several of the sex offender therapists interviewed. Neal had some

confidence that sex offender treatment had an effect on deviant arousal patterns, but his confidence was not strong.

> I'm undecided on changing arousal patterns. That's almost like trying to change a homosexual into a heterosexual….it's kind of like treatment is better than nothing.

Because treatment does not "cure" sexual deviancy (Pithers, Marques, Gibat, & Marlatt, 1983) and self-management is a life long process, no absolute conclusions are possible about the efficacy of sex offender treatment. Farrenkopf (1992) found that sex offender therapists over time become more pessimistic about the prospect of client change. Over half of the sex offender therapists he surveyed reported diminished expectations for the treated sex offenders to not re-offend. In a related survey of ninety-eight sex offender therapists, only six percent reported a stronger belief in treatment developing from their work with sex offenders (Jackson, Holzman, & Barnard, 1997). In general the comments on the efficacy of sex offender treatment by sex offender therapists in this study were very ambiguous. Melvin put it this way.

> I think that over time…you can't ever guarantee what a man will do once he gets out of prison. We as therapists don't have the ability to predict very well who's going to re-offend and who's not.

Mark told this story of his experiences as a sex offender therapist as if in response to the comment made by Sam. He had been working as a sex offender treatment provider for several years. He was respected in his community for providing a quality treatment program and filling an essential need for his community. He had ample confidence in the quality of the work he was doing and in the effectiveness of his program. When he

initiated the polygraph as a component of his treatment program he discovered nearly a ninety percent fail rate. Initially, he found the poor success rate highly disturbing. He then was able to reconcile his poor results by remembering the deceptive nature of the population he was working with. Ultimately the experience opened his eyes to how diligent he needed to be in his approach to sex offenders.

> It really did disturb me you know, so ever since then we have a saying around here, 'In God we trust, but all others we polygraph.' A lot of therapists don't do polygraphs in sex offender programs. My hunch is they don't want to find out if they're not doing a good job.

Current research in the area of sex offender treatment efficacy confirms some of the sex offender therapists' skepticism regarding the utility of their work (Furby, Weinrott & Blackshaw, 1989). It appears that this factor affects the sex offender therapist heavily while they endeavor to work as sex offender treatment providers. Of course the speculation about the utility of therapy in general is not unique to the field of sex offender treatment. But the emotional aftermath for sex offender therapist's related to client relapse is potentially more distressing than treatment failures in other types of clinical practice. If sex offender treatment fails, more innocent children may be victimized.

Increased Arousal

The fourth and final PTSD criteria relevant to this exploration of the vicarious traumatization of sex offender therapists are the increased arousal symptoms. In PTSD, the individual has persistent symptoms of anxiety or increased arousal that were not present before the exposure to trauma. The participants in this study provided some descriptions consistent with these criteria. There was some discussion of sleep

disturbance related to nightmares. Descriptions of irritability were mostly limited to anger toward sex offenders. Descriptions of changes in vigilance were most marked in those participants who had children of their own or were around children.

The sleep disturbance symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived. Kyle's description of re-experiencing nightmares has already been presented above. He admitted that the distress he experienced related to the traumatic dreams affected his ability to sleep for some time. Kevin described some sleep disturbance as well.

> I didn't really make the connection as to why I wasn't sleeping at the time. I'd never had any trouble sleeping before, and this was serious. I can remember whole nights I would just lay there not being able to sleep.

Some individuals report irritability or outbursts of anger. Several sex offender therapists described strong feelings of anger as a product of the work. Carrie was surprised both at the recognition that what she was feeling was anger and at how potently she was experiencing it.

> I was just so disgusted by what he had done with this little girl. I really wanted him to go back to prison, I wanted him to fail in the program outside and go back to prison.

For therapists, acknowledging such strong negative feelings as hate toward those who have come to them for help may be extremely difficult. Such feelings, when unacknowledged or inadequately addressed may have devastating consequences (Pope & Tabachnick, 1993). Carrie addressed how her feelings of anger toward the sex offender impacted her treatment approach toward him. She admitted that she wanted him to fail, to

not make therapeutic gains. This is certainly a sentiment that is rare in most therapeutic relationships. Carla's description focused even more directly upon the impact that her anger toward the sex offender had upon her personally.

> I don't know if it's anger toward sex offenders as much as hate. If I focus on all my hate for the offender, for what he did, it would drive me nuts.

Kyle reported that in discussions with his co-workers they talked a lot about being angry at sex offenders and even hating them sometimes. In discussing the dangerousness of a man soon to be released from prison, Kyle stated,

> He was just walking out of the prison, out to be around children who didn't know who he was. I remember thinking that he needed to be killed, and then thinking that there must be something wrong with me for thinking that.

Though sometimes difficult to admit, strong feelings such as anger or hate toward sex offenders are understandable. Managing these feelings can prove challenging for even the most committed clinician. When acknowledged and adequately addressed, such feelings can even serve as a therapeutic resource (Pope & Tabachnick, 1993).

The final criteria listed in the DSM-IV-TR are hypervigilance and an exaggerated startle response. The participants did describe feelings of concern for their own personal safety when working with sex offenders. Curtis described one encounter this way.

> We had a guy in group and he was a scary looking guy. His eyes just seemed reptilian you know. He'd done some pretty brutal things. I'd always been security conscious, now I was really security conscious.

Pope and Tabachnick (1993) in a study of 285 general therapy clinicians found that 53% indicated having felt so afraid about a client that it affected their eating,

sleeping or concentration. As with anger and hate, there are only meager research data about the extent to which therapists experience fear. Sam admitted that his safety concerns sometimes went so far as to affect the clinical approach he was able to use with certain clients.

> Personal safety is definitely a factor when working with sex offenders. You're more careful about you're level of confrontation and that sort of thing. That's something that usually doesn't happen in a client/therapist relationship.

Several of the therapists reported that they had become more alert to the potential dangers of sexual assault outside of work since they started working with sex offenders. They qualified this reaction as a natural product of becoming aware of the realities of sexual assault. Abel (1980) in his studies of sex offenders reported that 232 child molesters admitted attempting 55,000 incidents of sexual assault against children. 38,000 of these sexual assaults were completed. It is easy to see how a daily working awareness of this kind of information could affect the clinician's view of the world in general. A sense of security is basic to safety needs. Clinicians experiencing vicarious traumatization may feel there is no safe haven in a world so profuse with sexual assaults (Trippany, *et al*., 2004) Eve described her hypervigilance in these terms.

> Everywhere I go I see sex offenders. When I see a man who teaches girls softball, I'm suspicious. If I see a man at the park with a dog, I'm sure he's just using the dog to lure children to him.

Brown and Blount (1999) have reported finding that professionals who work with sex offenders report dramatic changes in their behavior toward their own children. Melvin described how his behavior with his two daughters had changed.

I've definitely talked to them about it. I hate to think that I've really scared them or made them paranoid, but they know why I'm careful and why I want them to be careful. A lot of kids don't know, but mine know.

Bengis (1997) reports that most sex offender therapists with any longevity in the field have learned to cope with 1) increased vigilance; 2) higher than average levels of anxiety about their children; and 3) projections of abuse motivation onto innocuous events. Community safety issues must be a constant primary consideration for sex offender therapists (O'connell, *et al.*, 1990). It is difficult to say if this vigilance is an aspect of competence for the sex offender therapist or a consequence of vicarious traumatization.

Constructivist Self-Development Theory

Psychologists are currently making an effort to shift their reliance upon a medical model that focuses on symptoms, to a relational model that focuses on the interaction of the clinician and the client and their mutual impact upon each other (Pearlman & Saakvitne, 1992). The Constructivist Self-Development Theory (CSDT) offers another framework for understanding the effects upon clinicians of secondary exposure to trauma that is different from that presented above. The premise of this theory is that individuals construct their realities through the development of cognitive schemas which facilitate their understanding of life experiences. CSDT supports the idea that changes in cognitive schemas occur in clinicians as a result of exposure to traumatic content in their work (Trippany, *et al*., 2004).

Defenses are employed to protect the cognitive schemas. These defenses closely resemble the vicarious traumatization symptoms reported by the participants above (i.e.,

avoidance, emotional numbing, isolation). In CSDT they are not regarded as symptoms, but instead as response patterns (McCann & Pearlman, 1992). These response patterns have an adaptive/protective value when initially employed. They can become entrenched and therefore non-adaptive when employed in a non-trauma context (Pearlman & Saakvitne, 1995). CSDT posits that adaptation to trauma results from a complex interplay between the clinician and the situation (McCann & Pearlman, 1992). It offers another theoretical framework for understanding the unique ways clinicians make sense out of and adapt to vicarious traumatization. According to CSDT, clinicians' responses to vicarious trauma are not symptoms, but are instead normal adaptive reactions to recurrent exposure to traumatic content (Clemans, 2003). These adaptive responses do not become problematic for all clinicians.

In CSDT, the emphasis is on the impact of trauma on cognitive schemas and the role of defenses in regulating the processing of traumatic content (McCann *et al*., 1988). This model draws on Horowitz' (1976) attempt to explain PTSD from a cognitive theory of information processing. Defensive processes are employed to protect the person from becoming overwhelmed until the traumatic content can be integrated into existing schemas (Horowitz, 1976). The cognitive schemas that are vulnerable to vicarious traumatization are: perception of self and others, safety, trust, esteem, independence, power, and intimacy (McCann & Pearlman, 1992). The participant's descriptions of their reactions to traumatic content in this study were consistent with this theory. According to Herman (1997), recurrent and pervasive exposure to traumatic content can lead to a transformation within the psychological functioning of the clinician. These shifts in the

cognitive schemas of clinicians can have detrimental effects on their personal and professional lives (Trippany, et al., 2004).

Dealing with Vicarious Traumatization

There is a general but unspoken code of silence that tends to prevent mental health professionals from discussing their more personal feelings of failure, frustration and disappointment (Maslach, 1986). MacCormack (2001) suggests that without some form of public sharing of these more difficult personal feelings related to therapeutic work, therapists run the danger of misinterpreting such feelings as incompetence rather than taking fully into account the inherent limitations of all psychotherapeutic endeavors. Though sometimes difficult to acknowledge, the occurrence of a wide range of feelings among therapists is understandable. This is especially true for those who work with traumatic issues such as sexual deviancy. Such feelings when unacknowledged can have detrimental consequences for the therapy, the client, and the therapist (Pope & Tabachnick, 1993). The responsibilities of therapeutic work are complex and cannot be carried out in an unfeeling manner. Acknowledging and trying to understand the feelings that come with the work may be just as important a part of the work as any other.

This section begins with the measures the participants used to selectively focus their attention onto something objective in order to curtail their subjective awareness of the content they were experiencing. These objective foci were task focus, client focus, and victim focus. Sharing the experience with other people was the most effective means reported for managing the impact of working with sex offenders. The use of humor lighten the mood was described as very important. The participants discussed how they were able to rely primarily on their peers at work in both formal and informal ways.

Some, but few, of the participants discussed accessing professional support outside of the work setting.

Selective Focus

It is understandable and in fact psychologically healthy, for the sex offender therapist to resist the impact of exposure to traumatic content. There is good reason not to hear or focus on the trauma. Exposure to traumatic content forces the clinician to accept realities that have been held at an intellectual distance (Dalenberg, 2000). A world unpopulated by the graphic details of sexual assault is decidedly more pleasant. A very effective way of shifting one's focus away and inhibiting one's own emotional reactions to this material is to train that focus onto something else entirely. Wilson and Lindy (1994) have reported that selective attention and empathic withdrawal from traumatic content are common responses for clinicians who have not been exposed to personal trauma themselves. They describe a state in which the clinician both withdraws and denies the significance of the withdrawal from traumatic content. Dalenberg (2000) has added that clinicians often use the protection of others as an excuse for or defense against their own resistance to exposure to traumatic material.

The sex offender therapists in this study identified three particular areas that they train their focus on while doing sex offender treatment. These areas are task focus, client focus and victim focus. Based upon the reports of the sex offender therapists, these are very effective pole-stars for countering many negative effects they might be experiencing as a product of working with sexually traumatic content. This shifting of focus is a very effective means to suppress emotional reactions that might otherwise occur. Suppression of affect could be a disguised version of vicarious traumatization (Dalenberg, 2000).

In the area of task focus the reports centered on descriptions of attempts to remain objective in the face of distracting or troublesome emotional reactions to traumatic content. Nelda describes this as a critical skill that she employs.

> It's kind of a disassociation in some ways. It's like it registers inside, but it never registers out here with what I'm doing with him. I think for me, when I hear it I think, now we're getting somewhere.

Kyle revealed how the importance he attributes to the task of sexual abuse prevention triggers him to remain objective at those times when his feelings might impair his effectiveness. He reported that no specific sex offender behavior affects him differently because he is focused intently on remaining objective while he works. He relied upon his commitment to the task of preventing future sexual assault and protecting the community.

> What do I do with the anger is a hard question. I think I have some ability to deal with it on an intellectual level and look at it in terms of I'm doing something important for the community.

Kevin defined himself as generally task focused and objective by nature. He described his experiences more as the recognition that this attribute of himself rendered him very suitable to working as a sex offender therapist.

> I'm a person who is more task oriented. I think to avoid it impacting you, you have to continually do some maintenance that this is about the offender. I approach it from an almost amoral point of view, just real valueless judgment.

A second focus the participants reported using was that of focusing on the sex offender himself. This section is closely aligned with earlier comments made about

compartmentalizing when dealing with sex offenders. These comments are addressed separately here to emphasize how the effects of compartmentalizing helped the sex offender therapists to mitigate their reactions specifically. These comments deal more with, what were the affects on the sex offender therapist when they utilized compartmentalization in their work with sex offenders. Carla described how it worked for her to focus on the sex offender with more compassion.

> I hurt for them when they were a child, I do. But they're not children anymore, they're adults. And so they're not here because of what somebody else did. They're here because of what they did.

Tapping into the therapist's compassion for the sex offender as a human being appears to have effectively shielded the therapist from some of the realities of the man's offending behaviors. Salter (1988) warns that this kind of empathizing with the sex offender can lead to minimizing their behavior and colluding with their rationalizations. Conversely, a lack of compassion can lead to an angry and punitive approach to the offender. In either case, the therapist's emotional task is greatly eased, but the offender's chance at rehabilitation is correspondingly lessened. Sam described how looking at the sex offender differently helped him to feel more compassion toward him. He talked about how putting himself in the sex offender's shoes gave him an insight into how to make treatment more tenable for them.

> People are basically doing the best they've got with what they have and even though his behavior was incomprehensible towards his victims, there was something inside of me that says 'Okay, there has to be something that initially motivated his behavior. It had to be something pretty awful.'

Nelda countered these reports with a warning that over-identifying with the sex offender could and often does have negative consequences for the therapist.

> I would always tell trainees don't look at the similarities look at the differences. You're going to find a lot of similarities and that's great but the differences are huge and glaring.

She warns that over-identifying can negatively impact the effectiveness of treatment. If the clinician over identifies with the sex offender she might not be as direct as is necessary when dealing with issues as seriously entrenched as sexual deviancy.

The final area of focus addressed by sex offender therapists as a means to mitigate their reactions to the content disclosed by sex offenders in treatment was victim focus. Victim focus is when the sex offender therapist attempts to balance her experience of the sex offender with whatever awareness she can foster of what the victims experience of the sex offender might have been. Kevin described it like this.

> Empathizing with the victim always keeps you grounded to who the sex offender really is. You should stay grounded to who they really are.

Carla added a description of how her victim focus motivates her to persevere as a sex offender therapist.

> I use the feelings I have of compassion for the victim and the hurt, to try to help me to get them to do something different. I don't focus on the man's victimhood.

Nelda provided this account of how she uses victim focus to guide her work with the sex offender in the moment.

> In the group, in the moment, I was feeling for his victim. We have to speak for the victim who isn't there.

Those who work in the helping professions tend to be individuals who are more sensitive to others (Pines & Aaronson, 1981). Figley (1995) asserts that this sensitivity is exactly what renders these individuals more susceptible to the effects of vicarious traumatization. This places the clinicians in a precarious situation. One the one hand, if they withdraw from the traumatic content, this could have negative consequences for themselves and for the treatment (Dalenberg, 2000). On the other hand, they must mitigate the effects of that exposure somehow.

Support

Although people tend to think of coping as an individual response, there is increasing evidence that social ties are an important factor in successful coping. If people have a supportive network of others that they can turn to for emotional support, they are better able to cope with various life stressors (Kilburg, 1986) Therapist's who work with sex offenders are struggling with issues, responses, and feelings that are considered largely unacceptable in American culture. These are very difficult issues to share with just anyone. It is vital that sex offender therapists have colleagues available for advice and support since working with sex offenders in isolation is potentially detrimental to all parties involved (Gerber, 1995).

Humor

The participants in this study provided multiple examples of how they were effective in accessing social support. Sharing a joke with friends or co-workers is an everyday experience for most people. Humor can serve as an excellent way to cut through tension and relieve stress (Pines & Aaronson, 1981). Humor based on the

realities of sexual assault was described as having an important place in the world of sex offender treatment. Larry noted this.

> Sort of talking about things from time to time, talking or telling stories or just various kinds of sick humor is another way of taking care of oneself.

Carrie put it this way.

> Jokes about sex offenders and even victims are one way we take care of ourselves, and make it less serious.

The idea of jokes about sex offenders and especially about sexual abuse victims would seem extremely inappropriate to most people. Sex offender therapists are very aware of this. Eve spoke about the conflict she experienced between the need to relate with others regarding her work, and the awareness of other's reacting negatively to how she attempted to relate through humor. She described a chance encounter with another sex offender therapist at a social engagement whom she had never met before.

> We were talking and laughing and joking and then when I looked up, we were sitting in my living room, and the rest of the whole group had gone in the kitchen. They didn't want to hear it. I felt bad about that. I haven't done that since, but it was nice for the two of us, to be able to talk about some of the stuff we'd seen.

In this description she appears to have reconciled herself to the fact that this outlet is an important one for her, but it is something she needs to exercise care with. The use of humor as a vehicle for tension relief and interpersonal connection is primarily to be used with the sex offender therapist's in-group only.

Utilizing Support

That in-group consists mainly of other sex offender therapists. It can include others who work directly with sex offenders such as policeman, attorneys, corrections staff and social workers. Those working together in the same agency are the primary support group that sex offender therapists rely on for processing the traumatic content they are exposed to in their work. Some of this in-group processing was informal and occurred in brief interactions or in passing, as described by Mark.

> It's pretty much all with the office staff here. Everybody's good about talking about it and I try to keep that largely here. That support that goes on here, makes this all worthwhile or something.

Giovannoni (1997) asserts that the most effective way to inhibit burnout among sex offender therapists is for them to process the effect that working with offenders is having on them. He encourages sex offender therapists to be willing to be vulnerable and share with a support group of colleagues the fears, emotional reactions and conflicts that are a regular part of sex offender treatment.

Other encounters were more formal and occurred in structured settings in which time was set aside specifically for this kind of processing. Carrie described how for her, reporting on how working with sex offenders was affecting her personally was a regular part of staff meetings.

> We would spend fifteen or twenty minutes talking about how that's affected us, and what could we do about it, or could we do anything. If this guy gives me the creeps, or disgusts me, we'd process that.

Supervision practices represent a pivotal opportunity to assist sex offender therapists in preventing the effects of vicarious traumatization. It is imperative that the

supervisor be aware of the potential negative effects of working with traumatic content. The supervisor must set a good example by modeling the discussion of how exposure to trauma in the work can have a negative impact on the therapist (Pearlman & Saakvitne, 1995).

Another example of in-group support was the occasion when very specific staff group meetings were convened just for the purpose of processing the effect of completing a re-enactment session with the sex offender. Re-enactments are not just descriptions of the sexual assault. They are graphically detailed descriptions accompanied by the sex offender acting out both his and the victims behaviors. These re-enactments can include the use of life-sized figures to represent the victim. The sex offender therapist walks out of this procedure with a good sense of having witnessed the sexual assault. These debriefing sessions usually immediately followed the re-enactment as Kevin reports.

> We generally met after re-enactment and broke it down. A lot of times therapists would come, you know vent and just talk about how abhorrent that behavior was and I think it did start to diffuse some of that.

Curtis described how critical these processing sessions were in order to keep the sex offender therapist from becoming more vulnerable in the work.

> If you're not willing to be self evaluative and take a look at yourself, you're going to have problems. You've got to be willing to be vulnerable to the people that you work with.

He spoke extensively about his sense of connection to other sex offender therapists as a result of debriefing the affects of the work..

> We have a knowingness and an awareness and understanding of something that is very different than how others see it.

This sense of connection serves a very positive purpose in providing the sex offender therapist access to a supportive community. Within their reports of a closeness with each other, there is an essence of alienation from the larger community. Curtis described this.

> This is part that I think is rather perplexing for people who don't do this work, and don't understand it. You've got to go through it. You can't just tell somebody about it. They've got to go through it.

His description sounds similar to the way Vietnam Veterans have described their sense of alienation from society in general and their close sense of kinship to other Vietnam Veterans (Mason, 1989). The dilemma for Curtis is that no one who has not been through the experience can possibly understand it and thereby know how it affects him. Only his in-group has this understanding, and only they can provide meaningful support.

> It seems that people who have worked together in that environment. You feel a sense of connection with them. More so than probably any professional experience that you've ever had. You know, you've gone through something really rather unique and rare.

For some, the support of other professionals not involved directly in sex offender treatment was an important means for processing the impact of the work. Carrie reported this.

> Consulting with other people and talking to other therapists is how I took care of myself.

Larry elaborated upon how interacting with other professionals in related fields helped him to keep his perspective about his own work more broad. He described how these interactions with others helped him to see his place in the bigger picture. It helped him to lessen his fixation on the specific details of his own work.

> Talking with colleagues who worked with kids, did prevention type work, I think that became important. It helped me to gain some sense of the impact of the behavior on kids.

Kevin provided a progressive account of the measures he took to access support from outside professionals. He begins with the recognition of his need for increased connection to support and for all those who work with sex offenders. He stated that in the case of outside professional support, the person needed to be someone who understood the ins and outs of sex offender treatment. An effective support person needed to be aware of what the sex offender therapist has to deal with. He asserted that someone outside the field could not have this understanding because sex offender treatment is so different from clinical work in general.

> I never really felt like I had a lot of support with regards to that from any other area. I couldn't really talk about it that much with individuals I was significantly involved with.

Kevin is alluding to the early difficulty he was having with his own concepts of human sexuality when he first began as a sex offender therapist. He reported feeling extremely isolated with these concerns because he had no mechanism for addressing

them without the fear of impugning his own sexuality. His description is consistent with the report of Bengis (1997) who stated that sex offender therapists inevitably become hypersensitive to even the slightest hint of sexual arousal or inappropriate sexual behavior. He was unaware that this was a frequent experience for sex offender therapists because no one he knew was talking about it. Kevin finally did reach outward to others for assistance with some general issues he was struggling with related to working with sex offenders. He talked to a psychologist that was outside of the program. He described how he needed individual professional help related to this specific area that was troubling him as a product of his work as a sex offender therapist.

> He helped me too see that okay, this is not about you. You're not a sexually deviant person that's preying on other people. What you're doing is not the same thing as what these guys are doing. There were times I should have talked more with professionals and I may not have had such an internal conflict.

Few clinicians work with sex offenders without becoming aware of the presence of personal changes in themselves resultant from the work. Some of these changes may be disturbing and simply not go away on their own. For the sake of their own well being and longevity in the field, sex offender therapists must address this dimension of the work. This exploration of the impact of the work on sex offender therapists has revealed that they mostly attempt to deal with these issues in isolation or within their own limited cohort. One cannot listen to the sexually abusive events described by sex offenders without eventually being inundated with intense feelings. The recurrent nature of that exposure only exacerbates the impact. Finding healthy ways for dealing with this impact is a challenge that all sex offender therapists face.

CHAPTER V

Discussion

I began this study with a strong interest in exploring the concept of sexual deviancy itself and specifically what sexual deviancy meant to the sex offender therapist. I hoped to address how that meaning played out in their work as sex offender therapists. I initially sought a concrete definition of sexual deviancy to better anchor sex offender treatment upon. Concrete definitions of sexual deviancy inevitably encounter exceptions or gray areas that when applied as absolutes can sometimes seem short of reason. A recent example in the media of a 17-year-old male being tried as an adult and receiving a 10-year sentence for having consensual sex with a 15-year-old female illustrates this point. The definition of sexual deviancy is a process that occasionally requires renegotiation.

The alternative of denying any objective validity to a construct like sexual deviancy because it is a social construction falters when applied as an absolute. The notion of middle-aged men having sex with infants is a clear illustration of this point for most people. Sexual deviancy is clearly a moral as well as a criminal issue (Szasz, 2002). The mental health profession endeavors to exert ample influence upon what many consider to be moral issues. Suicide, substance abuse, gambling and domestic violence are all human activities that the profession contends to exert some influence over. These behaviors, as well as sexual deviancy, are often considered to be criminal issues. While

social and political responses favor punishment, punishment alone has been recognized as inadequate as a complete response to sexual deviancy (Blanchard, 2002). My attempts to explore these specific issues with sex offender therapists were generally not fruitful. I began the exploration intent upon being open to what the participants were invested in sharing with me. I found this group of clinicians more invested in sharing with me the impact the work has had on them.

The purpose of this study was to add to the understanding of what the experience of being a sex offender therapist is like. The idea of contributing an improved understanding of this experience to the body of knowledge related to sex offender treatment is important because little exploration has been done in this area. It is important to me that I gain a better understanding of the experience myself. I look back on the three years that I worked as a sex offender therapist as an important period in my own life. I believe the experiences served as a catalyst for significant changes within me. I don't regret these changes, but it has been somewhat of a struggle to understand them meaningfully. I believe the process of completing this research project has helped me considerably in my efforts to gain a more encompassing awareness of what the experience of being a sex offender therapist entails.

It is a challenging proposition to be a sex offender therapist. There are many conflicting dynamics that come into play in this work. The sex offender therapist has to find some kind of balance on multiple issues. The sex offender therapist has to find meaning. That meaning is found through interactions with social and political influences. These influences include, the mental health profession, the judicial system, sex offenders,

other sex offender therapists, family and friends, and as Blumer (1969) would add, with the self.

Added to these issues is the exposure to the reality of sexual assault itself. Sex offender therapists must contend regularly with an awareness of sexual violence that most of the public are conveniently able to avoid contemplating. The adage which states that ignorance is bliss is distinctly apt in reference to the awareness of the cruelty that human beings are able to inflict upon each other. A cornerstone of the concept of vicarious traumatization is that this awareness leaves the therapist altered in a fundamental and long lasting, possibly permanent way (McCann & Pearlman, 1992).

My clinical supervisor at the time I was a sex offender therapist had herself only worked as such for two years prior to my joining the prison-based treatment program in which we worked. This proved advantageous for me as she was readily able to identify with the early phase issues of working with sex offenders that I inevitably encountered. She proved to be a valuable asset in aiding my successful navigation of some of these issues. I had the benefit of working with a program director that had over 25 years experience as a sex offender therapist. Her depth of experience gave her a viewpoint that helped her to guide me through many of the deeper social, psychological and professional issues related to sexual deviancy. Well before recent research in this area stressed the need for occupational and organizational measures to address the impact this work can have on the therapist (Farrenkopf, 1992), the agency in which I worked already had many of these measures in place. This fact afforded me ample opportunity to recognize and process the impact of the work upon me.

I was still left searching for a more global understanding to help me organize what I was experiencing and how I was managing it. The concept of burnout provided some fit but still did not capture the full experience. I had no knowledge of burnout having an effect upon the individual's concept of sexuality or altering dream content. Pines and Aaronson (1981) define burnout as a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations. Burnout is traditionally ameliorated by a change in work conditions. I was continuing to contend with some of my reactions to working with sex offenders over three years after I had moved on to other work.

I was in the process of completing my interviews and was in the process of coding the data before I became aware of the concept of vicarious traumatization. I spent a year submerged in the transcripts struggling for a way to organize and understand what the participants were trying to tell me. It was afterward, during the year I spent with the Veteran Administration working in a PTSD clinic, that I learned about vicarious traumatization. I was not provided with information on vicarious traumatization as a forecast of what I might expect as a product of my work with veterans (primarily Vietnam combat veterans). Instead, I noticed a subtle change in the content of my dreams. I have never been in combat and yet I began having combat related dreams that ultimately became very explicit. These dreams finally evolved into fairly accurate versions of combat experiences that veterans I was working with had disclosed in treatment.

With the help of my clinical supervisor in the PTSD clinic, I framed these dreams, and other experiences I was having in terms of counter-transference reactions to my

clients. A deeper theoretical exploration into the process of counter transference led me to the concept of vicarious traumatization. Wilson and Lindy (1994) provide a model for understanding types of therapist responses to working with combat trauma survivors. They elaborate on therapist responses that are primarily avoidant and those that involve over identifying with clients. Pearlman and Saakvitne (1995) address these same issues for therapists who work with sexual abuse victims. Empirical support that vicarious traumatization might be an issue for sex offender therapists is sparse, but early findings suggest that it is similar (Way *et al*., 2004).

Summary of Study

Twelve clinicians were interviewed in an attempt to capture descriptions of their experiences as sex offender therapists. The analysis of their experiences began with descriptions of the world of sex offender treatment. This discussion was important in that it provided a vivid context from which to better understand the effect the work has on the therapist. An especially salient aspect of that world is a review of the therapist's perceptions of sex offenders. Like most people, sex offender therapists find the behavior of sex offenders extremely objectionable. This group likewise generally found sex offenders to be objectionable as well. The sex offender therapists in this study strongly rejected the appropriateness of adult-child sex on the grounds that children were not, and even could not be willing participants in sexual activity due to their developmental inability to understand the sexual nature of the behavior.

The therapists reported that they perceived sex offenders to be particularly narcissistic and uncaring toward their victims and toward other people in general. They reported that they believed sex offenders were especially manipulative, dishonest, and

adept at avoiding personal responsibility for their behavior. They commented on the unusual tendency of sex offenders to become sexually aroused to stimuli that most people would not interpret as sexually stimulating.

In the discussion of the theories on what causes sexual deviancy, their responses broadly addressed a range of different etiological theories. The use of these theories in their work with sex offenders provided some guidance in their approach to sex offender treatment. The overall view was that these etiological theories did not provide adequate guidance in directing sex offender treatment because sexual deviancy was a highly individualized phenomenon and none of the theories captured the full range of these differences. The consensus was that why the sex offender committed the sexual assault was not as important a treatment issue as that he didn't re-offend.

Several of the participants commented on how interesting the work was as well. The consensus was that sex offenders were deviant and objectionable, but they were also complex human beings and of worth. There were elaborate measures employed to reconcile this conflict. One simple strategy was that if a sex offender does it, then it is deviant. If it was something I do, then it isn't deviant. None of the sex offender therapists were interested in exploring sexual abuse as a social construction. The sticking point on this issue appeared to be that children were often physically as well as emotionally harmed as a result of sexual abuse and this harm can not be merely a social construction.

The sex offender therapists in this study wanted to talk about what the work was like and how they weren't really strange people for undertaking this work. They reported extensively on their struggles managing some aspects of their place in society as sex

offender therapists, and their perception that their work may be undervalued by some. The importance of protecting society was a very important issue for them.

The second section of the analysis chapter began with a review of the DSM-IV-TR (2000) criteria for PTSD. The fact that I chose to use this framework is probably due to some degree on my own tendency to focus on symptoms in my clinical work. Vicarious traumatization is conceptualized as similar to PTSD but with sub-clinical symptoms. The qualifier of exposure to knowledge of the traumatic experiences of close associates is addressed. The therapist's descriptions of the impact of working with sex offenders are presented as they parallel these criteria for PTSD. Aside from the first criteria, exposure to trauma, the three other criteria are presented as symptom clusters. They include re-experiencing, avoidance, and increased arousal symptoms.

The participants reported very few re-experiencing symptoms. Some sleep disruption and disturbing dreams were described. A more consistent report related to intrusive thoughts and imagery. These descriptions centered on visualizing descriptions of sexual assault more clearly than was wanted as sex offenders described them. The therapist who had children themselves described occasions in which they experienced intrusive images of their own children being sexually assaulted.

The majority of analyzed effects of working with sex offenders fit into the avoidance criteria of PTSD symptoms. The sex offender therapist described extensively the efforts they employ in order to avoid thinking or talking about sex offender treatment when they are not at work. They described avoiding multiple activities that might remind them of aspects of their work such as news or entertainment programs or places where children are present. They described the lengths they went to in order to suppress or turn

off their emotions when they are exposed to traumatic content at work. Most of these measures exhibited some residual effect in that the therapists experienced these avoidance phenomena at times that they did not employ them volitionally.

The therapists described other residual effects that they attributed to working with sex offenders. A sense of alienation from others was a common theme. This was both a product of perceptions that others saw them as different and that they also saw themselves as different from other people. One aspect of this feeling different from others was due to a cynicism about people in general that was related to their unique awareness of the realities of sexual abuse and a concomitant suspiciousness of people in general. Some of the participants reported feeling differently about their own sexuality as a consequence of working with sex offenders. There were several pessimistic comments as well about the efficacy of sex offender treatment itself.

The third criteria, increased arousal symptoms, were only minimally reported by the participants in this study. Some of the therapist did report being more vigilant about the prospects of sexual assault in their environment, especially those with children of their own. The sex offender therapist described difficulties managing their anger toward sex offenders. The problems that this anger presented to effective treatment delivery were discussed. It was difficult to have both regard and anger toward the sex offender.

The final section of analysis addressed the coping skills the participants used to manage the impact the work had on them. Descriptions of these management strategies comprised the third major theme that arose from the interviews. The participants discussed the necessity of managing these emotional reactions to sex offenders. These management strategies appeared to cluster into two distinct groups. One way was to

effectively employ specific avoidance strategies, primarily cognitive, in order to suppress or lessen their emotional reactions. These avoidance strategies closely resembled the avoidance symptoms described in the previous section. The other method was to access a source of interpersonal support to process their emotional experience and integrate it more fully.

The sex offender therapists described cognitive coping skills that helped to ameliorate the impact of the work upon them. If they selectively focused on something other than the traumatic content, this helped them to better tolerate the work. This measure was to focus on the task of sexual abuse prevention and the importance of protecting future victims. This focus helped balance out the cost incurred from exposure to traumatic content.

Sex offender therapists primarily rely on the support of other sex offender therapist to process the impact their work has on them. This is mostly due to concerns that those outside the field will not be able to understand what the salient issues are, and may also be prone to taking a judgmental stance toward the therapist. Most of the participants described incidents in which they felt negatively judged by others due solely to the profession they had chosen. Some of the participants did describe positive interactions with people outside of the sex offender therapist group in which they found emotionally supportive allies.

Conclusion

Several years ago, as a sex offender therapist, I was a sitting in a treatment group watching a re-enactment of the vicious rape of a nine-year-old girl. The sex offender presenting the re-enactment was on his knees in the center of the group graphically

repeating the pleas he remembered from his victim. It became necessary for me to mentally retreat from this violent image. The image I retreated to was a scene of myself beating this man relentlessly with the chair that I was at the time sitting in. It was a disturbing event for me on more than one level. I was of course appalled at the reality of the re-enacted sexual assault I was witnessing. But I was especially disturbed at the intensity of this violent fantasy I was engaged in. I worried about what kind of person I was to have even considered such a thing. A couple of weeks later, I finally mentioned it to my supervisor. She casually responded "Oh yeah, you'll get used to those."

I don't think I ever did get used to those. Sex offender therapists have to do some major assimilation and accommodation in their work with sex offenders (Blanchard, 2002). The traumatic content that is the regular fare in sex offender treatment has got to be processed somehow. Trauma transforms people. Sometimes people grow through adversity and other times falter. These early findings may have some value in generating more rigorous studies into the effects and management of vicarious traumatization. A heightened recognition of the effects of vicarious traumatization on clinicians who attempt to help others will hopefully promote effective self-care techniques for the clinicians themselves.

Vicarious traumatization is considered a natural and inevitable response to spending significant amounts of time working with traumatic content. It is a process that takes place over time and across clients and therapeutic relationships. The impact is greater if the exposure is long term and recurring. Many of the effects experienced by the therapist parallel those of the trauma victim, but at sub-clinical levels (Pearlman and Saakvitne, 1995). Multiple aspects of the therapist and his life are affected, including

affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, and interpersonal relationships (McCann, *et al*., 1988).

This enquiry into the experience of clinicians working with sex offenders has developed into an exploration of the effects that the work has on the therapist. It focused on the specific experiences associated with this work that account for strong and even disturbing personal reactions. I began with the supposition that the work of sex offender therapists, while still containing the basic qualities of a therapeutic relationship found in general psychological work, possesses qualities unique to the domain of sex offender treatment. Therapists working in general practice often experience frustrations regarding lack of client progress toward treatment goals. Sex offender therapists likewise contend with these frustrations. Therapists working with general population clients rarely experience extreme anger, distrust and revulsion toward their clients. The therapists in this study reported these as common reactions in their work with sex offenders. The goal of this exploration was not specifically to discern those unique qualities, but instead to address the therapist's own emotional reactivity to experiences they encounter with sex offenders. The participants responded extensively to enquiries about their own emotional reactions to experiences they had working with sex offenders. The prominent themes that emerged were the nature of the therapist's reactions to working with sex offenders, and the strategies that the therapists employed to manage these reactions.

Polsom and McCollum (1995) have reported that in order for offender healing to occur that therapist caring is a critical factor. Sex offender therapists are not immune from the same reactions that most people have to emotionally laden content. Some mechanism or strategy must be employed to counter these negative reactions and

facilitate compassion and caring for the offender. Farber (1983) has reported that therapists in general must employ a number of defensive techniques to temper themselves from incipient feelings that could impinge upon their effectiveness with clients. Pines and Aaronson (1981) report that persons entering social science professions are even more predisposed to be interpersonally sensitive individuals and that such emotional arousal is especially taxing for them. Managing these reactions is therefore a paramount necessity for sex offender therapists if they hope to be effective and to remain in this specialization long enough to become proficient. Polsom and McCollum (1995) describe therapist caring as an active process, as work, as strategic cognitive frames for viewing offenders in a positive light.

The participants described a qualitative change in their approach to sex offenders once the offender accepted responsibility for his behavior. This appeared to be a strategy for managing the therapist's empathic identification with the sex offender. Accepting responsibility for the sexual offense and acknowledging the destructive nature of the sexual assault were critical factors that predicated a therapeutic alliance. I believe this mindset was illustrated by descriptions provided in which the therapists changed their approach to the sex offender after he accepted responsibility for his behavior. Only then did the therapists employ what one participant called a “compassionate approach" to treatment.

This compassionate approach often focused on two particular aspects of the offender. One was the probability that the offender was himself perhaps the victim of sexual abuse as a child and that this traumatic experience played some etiological role in his own sexually assaultive behavior. Sex offender therapists are better able to apply a

humanistic theoretical orientation to therapy with sex offenders by framing the offending behavior as somehow a product of the individual's own victimization as a child. The therapist stays aware of the fact that the man before her was once an innocent and vulnerable child who has been damaged himself and that the individual as he is now (an offender) is a victim; even his offending behavior is the product of victimization. Most of the participants reported attending specifically to this possibility in managing their emotional reactions to sex offenders.

It is evident from the reports of this group of clinicians that they encounter many situations in their work with sex offenders that prompt strong emotional reactions within them. It is evident that they have developed specific defensive strategies for managing these emotional reactions. It is less clear whether these management strategies either enhance the effectiveness of the work they do with sex offenders or even to what degree these strategies contribute to the sustained well-being of the therapists themselves. It is clear that the nature of the work does necessitate some kind of protective emotional detachment.

Recommendations for Further Research

These descriptions of coping strategies used by clinicians raise an important question: What methods of coping are most effective for clinicians who work with traumatic content? The participants in this study described effective strategies they employed to manage the impact that working with sex offenders had on them. Several of these descriptions included suggestions that the manner in which the therapists attempted to limit their responsiveness to traumatic content may have generalized inadvertently to their responsiveness in general. It would be important to operationalize the definitions of

these coping mechanisms in order to better explore both the positive and the negative effects of using them.

It has been demonstrated that many strategies are used to defend against the impact of vicarious traumatization. We still know relatively little about the recovery process of those exposed to traumatic events (Figley, 2002). It is important to study people who have been exposed to traumatic content and have not sought help. From such studies we may begin to establish accurate estimates of the full impact of this type of work on professionals. What are the major differences between those who are negatively impacted and those who are not? Information related to how these people manage the effects of exposure to this content could prove invaluable in providing support to those who are experiencing greater difficulty. The sex offender therapist who left the field could provide critical information in understanding the phenomenon of vicarious traumatization. What were the factors related to the work and to the individual that precipitated so drastic a response as quitting the field?

In his meta-analysis, Bride (2004) reported only fifteen published studies on secondary and vicarious traumatization. Research exploring the impact of exposure to traumatic content on clinicians is still in its infancy. Progress is impeded by a lack of consensus on what to call the phenomenon and what are its properties (Crabtree, 2002). A priority of research should be to develop a clearer definition of vicarious traumatization that could be used by all researchers. A clearer definition could lead to developing better ways of measuring the impact on the therapist. Regardless of the terms that may or may not adequately describe the impact on clinicians who work with traumatic content, there is strong evidence that vicarious traumatization can have negative, cumulative and

prolonged effects (Black & Weinreich, 2000). In light of the findings of this research, it is imperative that clinicians be made more aware of the potential impact of vicarious traumatization.

Another question that arose from this study is how long do the effects of vicarious traumatization last? The alteration of personal schemas that can result from exposure to traumatic content can be highly resistant to change and possibly permanent (McCann & Pearlman, 1992). McCann, Sakheim and Abrahamson (1988) propose that some of the disruption that occurs through traumatic exposure is specific to certain schemas. These include; safety, trust, power, esteem, and intimacy. While many of the reported effects here are consistent with these themes, this study did not explore schema disruption expressly. In future studies, it would be important to determine what the effects are with sex offender therapists in this area.

One of the long lasting effects reported was how the clinicians view of the sex offender changed. The participants in this study described changes in their perceptions of sex offenders. It would be interesting to determine what these changes were and what facilitated the changes. A likely change that the sex offender therapist might recognize in the offender is a positive or negative response to treatment itself. Sex offender treatment efficacy is a complicated issue. Sex offender therapists are necessarily engaged in the ongoing process of evaluating the treatment progress of the offender. This process is both formal and informal. What are the indicators that sex offender therapists attend to in making their progress assessments? A better understanding of this issue might add some clarity to the difficulties inherent in efficacy studies on sex offender treatment.

Implications for Practice

Results of this study may have been limited by several factors. First, the small sample size is acknowledged. This is an exploratory study and a small sample was intentionally selected to facilitate an in depth exploration of the participants' experiences. Second, the sample was not homogenous. The experience as a sex offender ranged from three to thirty years. The age range was from 36 to 61 years old. There were both men and women in the study. Some worked in prison settings and others in community treatment programs. However, it may be equally argued that such diversity provides a greater exposure to diverse experiences.

The sex offender therapists in this study identified multiple strategies they used for coping with, and preventing the negative effects of their work. The range of individualized strategies reported on both personal and professional levels suggests a high level of awareness of the need to care for themselves. The coping and preventive strategies used by these therapists were consistent with the strategies identified in the vicarious traumatization literature. This is interesting considering only one of the participants was familiar with these fairly recent research developments. I believe that vicarious traumatization is a viable concept for describing the effect that working with sex offenders has on the therapist.

It is not my intention to assert that sex offender therapists necessarily suffer at sub-clinical levels from PTSD. PTSD is itself a controversial diagnosis (Dineen, 1996). Applying the diagnostic criteria of PTSD to these descriptions of the effects of working with sex offenders is not meant to minimize the seriousness of the impact on the victims of traumatic events such as combat experience or sexual assault. Neither is it meant to

exaggerate the effect on the therapist from exposure to clients' descriptions of their traumatic experiences. The concept of vicarious traumatization and the diagnostic criteria for PTSD merely provide a useful template for organizing and understanding the reported effects of secondary exposure to traumatic content.

Dineen (1996) warns that over-utilizing the concept of PTSD can produce the undesirable effect of manufacturing victims. People who have bad dreams after watching scary movies are not likely to be suffering from PTSD. But scary movies do affect people. The content of one's environment affects the person. The recurring content of the sex offender therapists' working environment is laden with traumatic material. Vicarious traumatization and its varied premises offer some direction in explaining the effect of exposure to this content on the therapist. A very tangible utility of the concept of vicarious traumatization is that it offers a way for the sex offender therapist to address the effect the work is having on him.

It is not my intention to imply that all sex offender therapists have vicarious traumatization. Some do not. Individuals respond differently to trauma. Not all those who experience traumatic events develop PTSD. There are a host of predisposing and ameliorative factors that contribute to the manifestation of PTSD (Meichenbaum, 1994). This is likely the case with vicarious traumatization. A basic premise of PTSD treatment is that whether or not an event is experienced as traumatic depends very much on the individual. The impact is a product of the unique interaction of the event with the person's perception of the event and his ability to cope with it. In a traumatic exposure, the individual's ability to integrate affective experience is overwhelmed (Herman, 1997). Several strategies have been proposed to assist the clinician in integrating the experience

of secondary exposure to trauma (Cornille & Meyers, 1999; Figley, 2002; Trippany, *et al*., 2004).

Peer support was the most effective venue described by the participants in this study. Consultation with colleagues provided an opportunity to debrief and express emotions and to decrease the intensity of negative reactions. This is a critical facet in ameliorating the impact of working with traumatic content and should be a formal organizational aspect for the therapist who works in sex offender treatment. If this became the standard mode of operation for those who deal with traumatic experiences as part of their work, it could de-stigmatize and de-pathologize the seeking of help (Meichenbaum, 1994). Supervisors who work with sex offender therapists should regularly explore the impact that the work is having on the clinician, as well as how that impact then effects treatment.

Ideally the therapist new to sex offender treatment should have training focused on the impact of secondary exposure to trauma. This is vital and should be provided to both new and continuing sex offender therapists. Those new to sex offender treatment may need additional forums for checking out how they are responding to the work, how they are managing their counter-transference reactions to sex offenders and what their understanding of vicarious traumatization is. Clinician's with an awareness of the potential changes in themselves as a result of their work are likely to be less impacted by vicarious traumatization (Trippany *et al*., 2004). The new sex offender therapist may need assistance to develop ways of helping his family and friends understand what she is experiencing.

The impact of vicarious traumatization can be reduced when clinicians maintain a balance between their personal and professional lives. This balance includes engaging in social activities that aid in preserving a sense of identity less related to the realities of sexual assault. The defenses employed to protect oneself from the knowledge of human cruelty have their own costs (Pearlman & Saakvitne, 1995). Without a larger range of experience to balance the clinicians sense of meaning, she may become cynical, withdrawn, emotionally numb and outraged (Herman, 1992). Clinicians need to actively engage with the larger community to increase their sense of connection to it. The participants in this study recommended interacting with others completely outside the world of sex offender treatment as an important aspect of self care.

Therapist self-care is more likely to be addressed by individual clinicians if it is supported organizationally. Agency's that support sex offender treatment should explore the benefits of support systems for clinicians. This support might include facilitated support groups and confidential access to personal therapy for the clinician. Concrete needs such as reasonable work schedules and caseloads, and adequate pay are necessary. Organizations must send the message that the well being of the clinician is important. These efforts to communicate and facilitate support for clinicians can help to prevent stress related problems and thereby improve the quality of sex offender treatment.

REFERENCES

Abel, G. (1980). Preventing men from becoming rapists. In G.S. Albee and H. Leltenberg (Eds.), *Promoting sexual responsibility and preventing sexual problems* (Pp. 238-250). New Hampshire: University Press of New England.

Alexander, R. (1997). Reconstructing sex offenders as mentally ill: A labeling explanation. *Journal of Sociology and Social Welfare, 34*(2), 65-75.

Amen, T.M. (2002). An investigation of the psychological consequences to sex offender treatment providers. Unpublished doctoral dissertation, Sam Houston State University, Huntsville, Texas. Retrieved October 4, 2005, from http://wwwlib.umi.com/dissertations

American Psychiatric Association. (2000). *The diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Anechiarico, B. (1998). A closer look at sex offender character pathology and relapse prevention: An integrative approach. *International Journal of Offender Therapy and Comparative Criminology, 42*(1), 16-26.

Arvay, M.J.,& Uhleman, M.R. (1996). Counselor stress in the field of trauma: A preliminary study. *Canadian Journal of Counseling, 30*(3), 193-210.

Aponte, H., & Winter, J. (1987). The person and practice of the therapist: Treatment and training. In M. Baldwin & V. Satir (Eds.), *The use of self in therapy* (Pp. 85-111). New York: Haworth.

Becker, H.S. (1963). *Outsiders: Studies in the sociology of deviance*. New York: Macmillan Publishing Company.

Becker, H.S. (1987). *Tricks of the trade: How to think about your research while you're doing it.* Chicago: The University of Chicago Press.

Beehr, T.A., Johnson, L.B., & Nieva, R. (1995). Occupational stress: Coping of police and their spouses. *Journal of Organizational Behavior, 16*(1), 3-25.

Bengis, S.B. (1997). Personal and interpersonal issues for staff working with sexually abusive youth. In S.B. Edmunds (Ed.), *Impact: Working with sexual abusers* (Pp. 31-50). Vermont: Safer Society Press.

Berg, B. L. (1998). *Qualitative research methods for the social sciences.* Boston: Allyn & Bacon.

Berliner, F. S., & Meinecke, C. F. (1981). Treatment of sex offenders with antiandrogenic medication: Conceptualization, review of treatment modalities, and preliminary findings. *American Journal of Psychiatry, 138*(5), 601-607.

Bersoff, D.N. (1976). Therapists as protectors and policemen: New roles as a result of Tarasoff? *Professional Psychology, 7,* 267-273

Bernard M., Fuller, S., Robbins, E., & Shaw, M. (1989). *The child molester.* New York: Plenum Press.

Black, S., & Weinreich, P. (2000). An exploration of counseling identity in counselors who deal with trauma. *Traumatology, 6*(1), 64-81.

Blanchard, G.T. (2002). *The difficult connection: The therapeutic relationship in sex offender treatment.* Vermont: Safer Society Press.

Bloom, S.L. (1993). Vicarious traumatization and therapist self-care. *Traumatic Stress Points: News for the International Society for Traumatic Stress Studies, 7*(3), 3-4.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Berkeley: University of California Press.

Bogdan, R. C., & Biklen, S. K. (1992). *Qualitative research for education: An introduction to theory and methods.* Boston: Allyn & Bacon, Inc.

Bride, B.E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis, 7,* 29-46.

Briere, J. (1989). *Therapy for adults molested as children: Beyond survival.* New York: Springer Publishing Company.

Briggs, F. (1995). *From victim to offender: How child sexual abuse victims become offenders.* Australia: Allen & Unwin.

Brown, J., & Blount, C. (1999). Occupational stress among sex offender treatment managers. *Journal of Managerial Psychology, 14*(2), 108-115.

Butler, S. (1985). *Conspiracy of silence: The trauma of incest*. California: Volcano Press, Inc.

Carr, C.L. (1999). Cognitive scripting and sexual identification : Essentialism, anarchism, and constructionism." *Symbolic Interaction, 22*(1), 1-24.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N.K. Denzin and Y.S. Lincoln (Eds.), *Handbook of qualitative research* (Pp. 509-535). California: Sage Publications.

Clemans, S.E. (2003). Understanding vicarious traumatization: Strategies for social workers. *Social Work Today, 4*(2), 13-18.

Cornille, T.A., & Meyers, T.W. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology, 5*(1). 77-95.

Costler, A., & Willy, A. (1937). *Encyclodaedia of sexual knowledge*. New York: Eugenics Publishing Company.

Crabtree, D. (2002). Vicarious traumatization in therapists who work with juvenile sex offenders. Unpublished doctoral dissertation, Pace University, New York, New York. Retrieved October 4, 2005, from http://wwwlib.umi.com/dissertations

Crabtree, B.F., & Miller, W.L. (1992). *Doing qualitative research.* Newbury Park, California: Sage Publications.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Thousand Oaks, California: Sage Publications.

Curtois, C.A. (1993). Vicarious traumatization of the therapist. *NCP Clinical Newsletter, 3*(2). 24-27.

Dalenberg, C.J. (2000). *Countertransference and the treatment of trauma.* Washington, DC: American Psychological Association.

Davies, C. (1979). The social origins of some sexual taboos. In M. Cook, & G. Wilson (Eds.), *Love and Attraction* (pp. 381-386). Oxford: Pergamon Press.

Davies, C. (1982). Sexual taboos and social boundaries. *American Journal of Sociology, 87*(5), 1032-1063.

DeLamater, J. (1981). The social control of sexuality. *Annual Review of Sociology, 7,* 263-290.

DeLamater, J. (1987). A sociological approach to human sexuality. In J. H. Geer, & W. T. O'Donohue (Eds.), *Theories of human sexuality*. New York: Plenum Press.

D'Emilio, J., & Freedman, E. B. (1988). *Intimate matters: A history of sexuality in America.*" New York: Harper and Row Publishers.

Derogatis, L. (1975). *Brief Symptom Inventory.* Baltimore: Clinical Psychometric Research.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry.* San Diego: Academic Press.

Dineen, T. (1996). *Manufacturing victims: What the psychology industry is doing to people.* New York: Robert Davies Multimedia Publishing.

Downes, D., & Rock, P. (1988). *Understanding deviance: A guide to the sociology of crime and rule breaking.* Boston: Oxford University Press.

Dwyer, S. M. (1997). Treatment outcome study: Seventeen years after sexual offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 9*(2), 149-160.

Ellerby, L., Gutkin, B., Smith, T., & Atkinson, R. (1993). *Treating sex offenders: The impact on clinicians.* Poster Presentation, 12th Annual Conference of the Association for the Treatment of Sexual Abusers, Boston, Massachusetts.

Edmunds, S.B. (1997). The personal impact of working with sex offenders. In S.B. Edmunds (Ed.), *Impact: Working with sexual abusers* (Pp. 11-30). Vermont: Safer Society Press.

Emory, L.E., Cole, C.M., & Meyer, W.J. (1992). The texas experience with depoprovera: 1980-1990. In E. Coleman, S.E. Dwyer, and N.J. Pallone (Eds.), *Sex offender treatment: Psychological and medical approaches*. (Pps. 125-140). New York: Haworth Press, Inc.

Farber, B. (1983). Dysfunctional aspects of the psychotherapeutic role. In B. Farber (Ed.), *Stress and burnout in the human service professions* (Pp. 97-116). New York: Pergamon Press.

Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? In E. Coleman, S.M. Dyer, & N.J. Pallone (Eds.), *Sex offender treatment: Psychological and medical approaches* (Pp. 217-223). New York: The Haworth Press, Inc.

Figley, C.R. (1988). Victimization, trauma, and traumatic stress. *The Counseling Psychologist, 16*(4), 635-641.

Figley, C.R. (1995). *Compassion fatigue: Secondary traumatic stress disorder*. New York: Brunner/Mazel.

Figley, C.R. (2002). Compassion fatigue: psychotherapists' chronic lack of self care. *Psychotherapy in Practice, 58*(11), 1433-1441.

Finklehor, D., & Lewis, I.A. (1988). An epidemiological approach to the study of child molestation. In R. Prentsky and V. Quinsey (Eds.), *Human sexual aggression: Current perspectives* (Pp. 64-78). New York: Annals of the New York Academy of Science.

Fisher, D., & Beech, A.B. (1999). Current practice in Britain with sexual offenders. *Journal of interpersonal violence, 14*(3), 240-256.

Flandrin, J. (1976). *Families in former times: Kinship, household and sexuality*. Cambridge: Cambridge University Press.

Flora, R. (2001). *How to work with sex offenders: A handbook for criminal justice, human service, and mental health professionals.* New York: The Haworth Clinical Practice Press.

Foucault, M. (1975). *Discipline and punish: The birth of the prison.* New York: Vintage Books.

Foucault, M. (1978). *The history of sexuality: Volume 1 an introduction.* New York: Pantheon Books.

Francoeur, R. T., Koch, P. B., & Weis, D. L. (1998). *Sexuality in America: Understanding our sexual values and behavior.* Continuum Press: New York.

Freeman-Longo, R.E. (1997). A personal and perspective on burnout. In S.B. Edmunds (Ed.), *Impact: Working with sexual abusers* (Pp. 5-9). Vermont: Safer Society Press.

Freud, A. (1946). *The ego and the mechanisms of defense.* New York: International Universities Press.

Freund, K. (1972). The female child as a surrogate object. *Archives of Sexual Behavior, `2*(2), 119-133.

Furby, L., Weinrott, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105*(1), 3-30.

Gagnon, J., & Simon, W. (1973). *Sexual conduct: The social sources of human sexuality*. Chicago: Aldine Publishing Company.

Garlick, I. (1996). Intimacy deficits and attribution of blame among sex offenders. *Legal and Criminological psychology, 1,* 251-258.

Gebhard, P.H. (1965). *Sex offenders: An analysis of types*. New York: Harper and Row.

Gentry, E., Baranowsky, A.B., & Dunning, K. (1997, November). Accelerated recovery program for compassion fatigue: Treatment and training protocols. Presented at the Thirteenth Annual International Society for Traumatic Stress Conference, Montreal, Quebec, Canada.

Gerber, P.N. (1995). Commentary on counter-transference in working with sex offenders: The issue of sexual attraction. *Journal of child sexual abuse, 4*(1), 117-120.

Gergen, K.J. (2001). Psychology as "politics by other means." Presented at the International Society for Theoretical Psychology, Calgary, Canada

Giddens, A. (1992). *The transformation of intimacy, sexuality, love and emotion in modern societies*. California: Stanford University Press.

Gilligan, J. (1996). *Taming the criminal.* New York: Macmillan.

Giovannoni, J. (1997). Increasing efficacy and eliminating burnout in sex-offender treatment. In S.B. Edmunds (Ed.), *Impact: Working with sexual abusers* (Pp. 89-99). Vermont: Safer Society Press.

Glaser, B.G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* California: Sociology Press.

Glaser, B.G., & Strauss, A. (1967). *The discovery of grounded theory.* Chicago: Aldine

Goldberg, C. (1996). *Speaking with the devil: Exploring senseless acts of violence.* New York: Penguin Books.

Golden-Biddle, K., & Locke, K.D. (1997). *Composing qualitative research.* California: Sage Publications.

Gove, W.R. (1975). The labeling of deviance: Evaluating perspectives. *Vanderbilt Sociology Conference 3rd*. New York: Sage Publications

Gratzer, T., & Bradford, J.M.W. (1995). Offender and offense characteristics of sexual sadists: A comparative study. *Journal of Forensic Sciences, 40*(3), 450-455.

Grosch, W.N., & Olsen, D.C. (1994). *When helping starts to hurt: A new look at burnout among psychotherapists.* New York: Norton.

Groth, N. (1979). *Men who rape: The psychology of the offender.* New York: The Plenum Press.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24*(1), 57-74.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report on the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194.

Herman, J.L. (1997). *Trauma and Recovery.* New York: Perseus Books Group

Higginson, J. G. (1999). Defining, excusing, and justifying deviance: Teen mothers' accounts for statutory rape. *Symbolic Interactionism, 22*(1), 25-44.

Hills, S.L. (1980). *Demystifying social deviance.* New York: McGraw-Hill Book Company.

Horowitz, M. (1974). Stress response syndromes: Character style and brief psychotherapy. *Archives of General Psychiatry, 31,* 769-781.

Horowitz, M. (1976). *Stress response syndromes.* New York: Jason Aronson.

Jackson, K.E., Holzman, C., & Barnard, T., (1997). Working with sex offenders: The impact on practitioners. In S.B. Edmunds (Ed.), *Impact: Working with sexual abusers* (Pp. 61-74). Vermont: Safer Society Press.

Janik, J. (1995). Addressing cognitive defenses in critical incident stress. *Journal of Traumatic Stress, 5,* 497-503.

Joslyn, H. (2002). Defeating compassion fatigue: Charities seek ways to prevent employees from burning out. *Chronicle of Philanthropy, 14*(12), 37-39.

Justice, B., & Justice, R. (1979). *The broken taboo: Sex in the family*. New York: Human Sciences Press.

Kadambi, M.A. (1998). Vicarious trauma among therapists working with sex offenders. Unpublished master's thesis, University of Alberta, Edmonton, Alberta, Canada. Retrieved October 4, 2005, from http://wwwlib.umi.com/dissertations

Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (Pp. 37-48), Maryland: Sidran Press.

Kear-Colwell, J., & Pollock, P. (1997). Motivation or confrontation: Which approach to the child sex offender? *Criminal Justice and Behavior, 24*(1), 20-33.

Kearns, B. (1995). Self-reflection in work with sex offenders: A processnot just for therapists. *Journal of Child Sexual Abuse, 4*(1), 107-110.

Kerlinger, F. (1973). *Foundations of behavioral research* (2nd ed.). New York: Holt, Reinhart and Winston.

Kersting, K. (2003). New hope for sex offender treatment. *Monitor on Psychology, 34*(7), 52-53.

Kinsey, A., Pomeroy, W., & Martin, C. (1948). *Sexual behavior in the human male.* Philadelphia: W.B. Saunders.

Kilburg, R.R. (1986). The distressed professional: The nature of the problem. In R. Kilburg, P. Nathan & R. Thoreson (Ed.), *Professionals in distress: Issues, syndromes and solutions in psychology* (Pps. 2-13).Washington, DC American Psychological Association.

Kirk, S. (1977). Society and sexual deviance. In H. Gochros, & J. Gochros (Eds.) *The sexually oppressed (pp. 28-37)*. New York: Association Press.

Kolb, D. (1984). *Experiential learning as the source of learning and development.* New Jersey: Prentice Hall.

Lab, S. P., Shields, G., & Schondel, C. (1993). Research note: An evaluation of juvenile sexual offender treatment. *Crime and Delinquency, 39*(4), 543-553.

Langevin, R. (1990). Sexual anomalies and the brain. In W.L. Marshall, D.R. Laws, and H.E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender,* (Pps. 103-113), New York: Plenum Press.

Lantz, H. R., Keyes, J., & Schultz, M. (1975). The American family in the reindustrialize period: From base lines in history to change. *American Sociological Review, 40,* 21-36

Laws, R. (1989). *Relapse prevention with sex offenders.* New York: The Guilford Press.

Leahey, T. H. (1992). *The history of psychology: Main currents in psychological thought*. New Jersey: Prentice Hall.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry.* Newbury Park: Sage Publications.

Lincoln, Y.S., & Guba, E.G. (1986). But is it rigorous? Trustworthiness, and authenticity in naturalistic evaluation. In D. D. Williams (Ed.), *New directions for program evaluation,* (Pp. 73-84). San Francisco: Jossey-Bass.

Lindy, J.D. (1988). *Vietnam: A casebook.* New York: Brunner/Mazel Publications.

Longmore, M. (1998). Symbolic interactionism and the study of sexuality. *Journal of Sex Research, 35*(1), 44-58.

Lyon, E. (1993). Hospital staff reactions to accounts by survivors of childhood abuse. *American Journal of Orthopsychiatry, 63,* 410-416.

MacCormack, T. (2001). Let's get personal: Exploring the professional persona in health care. *The Qualitative Report 6(3)*. Retrieved November 29, 2004, from http://www.nova.edu/ssss/QR/QR6-3/maccormack.html

Malan, D.H. (1976). *The frontier of brief psychotherapy: An example of the convergence of research and practice.* New York: Plenum Press.

Marmor, J. (1971). "Normal" and "deviant" sexual behavior. *The Journal of the American Medical Association, 217*, 97-107.

Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of cognitive-behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. *Criminal Justice and Behavior, 21*(1), 28-54.

Marques, J. K., Nelson, C., West, M. A., &Day, D. M. (1994). The relationship between treatment goals and recidivism among child molesters. *Behavior Research and Therapy, 32*(5), 577-588.

Marques, J. K. (1999). How to answer the question: "Does sex offender treatment work?" *Journal of Interpersonal Violence, 14*(4), 437-451.

Marshall, C.,& Rossman, G.B. (1995). *Designing qualitative research* (2nd ed.). Thousand Oaks: Sage Publications.

Martin, D.D. (2002). From appearance tales to oppression tales: Frame alignment and organizational identity. *Journal of Contemporary Ethnography, 31*(2), 158-206.

Maslach, C. (1986). Stress, burnout, and workaholism. In R. Kilburg, P. Nathan & R. Thoreson (Eds.), *Professionals in distress: Issues, syndromes and solutions in psychology,* (Pp.53-76).Washington, DC American Psychological Association.

Mason, P. (1989). *Recovering from the war: A guide for all veterans, family members, friends, and therapists.* High Springs, Florida: Patience Press.

Masters, W., & Johnson, V. (1966). *Human sexual response*. Boston: Little Brown.

McCann, L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *The Journal of Traumatic Stress, 3,* 131-149.

McCann, L., & Pearlman, L.A. (1992). Constructivist self-development theory: A theoretical model of psychological adaptation to severe trauma. In D.K. Sakheim, & S.E. Devine (Eds.), *Out of darkness: Exploring satanism and ritual abuse* (Pp. 185-206) New York: Lexington Books.

McCann, L.I., Sakheim, D.K., & Abrahamson, D.J. (1988). Trauma and victimization: A model of psychological adaptation. *The Counseling Psychologist, 16*(4), 531-594.

McConaghy, N. (1999). Methodological issues concerning evaluation of treatment for sexual offenders: Randomization, treatment dropouts, untreated controls, and within-treatment studies. *Sexual Abuse: A Journal of Research and Treatment, 11(3)*, 183-194.

McGarry, M. (2000). Spectral sexualities: Nineteenth-century spiritualism, moral panics, and the making of the U.S. obscenity law. *Journal of Women's History, 12(2)*, 8-26.

McLean, S., Flinders, U., Adelaide, S.A., & Wade, T.D. (2003). The contribution of therapist's beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion. *Behavioral and Cognitive Psychotherapy, 31*(4), 417-428.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with post traumatic stress disorder (PTSD).* Ontario: Institute Press.

Meldrum, L., King, R., & Spooner, D. (2002). Compassion fatigue in community mental health case managers. In C.R. Figley (Ed.), *Treating compassion fatigue.* New York: Brunner Rutledge.

Merriam, S.B. (1998). *Qualitative research and case study applications in education.* California: Jossey-Bass Publishers.

Millon, T., Millon, C, & Antoni, M. (1986). Sources of emotional and mental disorder among psychologists: A career development perspective. In R.R. Kilberg, P.E. Nathan & R.W. Thoreson (Eds.), *Professionals in distress: Issues, syndromes and solutions in psychology,* (Pp.119-134).Washington, DC American Psychological Association.

Moran, C., & Britton, N.R. (1994). Emergency work experience and reactions to traumatic incidents. *Journal of Traumatic Stress, 7*(3), 575-585.

Morgan, G. (1983). *Beyond methods: Strategies for social research.* Beverly Hills, California: Sage Publications.

Nathan, P.E. (1986). Unanswered questions about distressed professionals. In R. Kilburg, P. Nathan & R. Thoreson (Ed.), *Professionals in distress: Issues, syndromes and solutions in psychology,* (Pp. 27-36).Washington, DC American Psychological Association.

O'Connell, M.A., Leberg, E., & Donaldson, C. R. (1990). *Working with sex offenders: Guidelines for therapist selection.* Newbury Park: Sage Publications.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks: Sage Publications.

Pearlman, L.A., & MacIan, P.S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558-565.

Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatizationin psychotherapy with incest survivors.* New York: W.W. Norton and Company.

Perry, B.D. (2003). *The cost of caring: Secondary traumatic stress and the impact of working with high-risk children and families*. Retrieved April 18, 2005, from http://www.ChildTrauma.org

Pfafflin, F. (1992). What is in a symptom? A conservative approach in the therapy of sex offenders. In E. Coleman, S.E. Dwyer, and N.J. Pallone (Eds.), *Sex offender treatment: Psychological and medical approaches,* (Pps. 5-18). New York: Haworth Press, Inc.

Piaget, J., & Inhelder, B. (1969). *The psychology of the child.* New York: Basic Books.

Pines, A., & Aaronson, E. (1981). *Burnout: from tedium to personal growth*. New York: The Free Press.

Pithers, W. D. (1994). Process evaluation of a group therapy component designed to enhance sex offenders' empathy for sexual abuse survivors. *Behavior Research and Therapy, 32*(5), 565-570.

Pithers, W.D., Marques, J.K., Gibat, C.C., & Marlatt, G.A. (1983). Relapse prevention with sexual aggressives: A self-control model of treatment and the maintenance of change. In J.G. Greer and I.R. Stuart (Eds.), *The sexual aggressor: Current perspectives on treatment,* (Pp. 292-310). New York: Guilford.

Plummer, K. (1975). *Sexual stigma: An interactionist account*. London: Routledge & Kegen Paul.

Polizzi, D. M., MacKenzie, D. L., & Hickman, L. J. (1999). What works in adult sex offender treatment? A review of prison- and non-prison-based treatment programs. *International Journal of Offender Therapy and Comparative Criminology, 43*(3), 357-374.

Polson, M., & McCullom, E. (1995). Therapist caring in the treatment of sexual abuse offenders: Perspectives from a qualitative case study of one sexual abuse treatment program. *Journal of Child Sexual Abuse, 4*(1), 21-37.

Pope, K.S., & Tabachnick, B.G. (1993). Therapists' anger, hate, fear. And sexual feelings: National survey of therapists responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice, 24*(2), 142-152.

Psathas, G. (1973). *Phenomenological sociology: Issues and applications.* New York: Wiley Publications.

Rasmussen, B. (2005). An intersubjective perspective on vicarious traumatization and its impact on the clinical process. *Journal of Social Work Practice, 19*(1), 19-30.

Raymond, N. C., Coleman, E., Ohlerking, F., Christenson, G., & Miner, M. (1999). Psychiatric comorbidity in pedophilic sex offenders. *The American Journal of Psychiatry*, *156*(5), 786-788.

Reddon, J. R., Payne, L. R., & Starzyk, K. B. (1999). Therapeutic factors in group treatment evaluated by sex offenders: A consumers' guide, *Journal of Offender Rehabilitation, 28*(3/4), 91-101.

Reese, W. A., & Katovich, M. A. (1989). Untimely acts: Extending the interactionist conception of deviance. *The Sociological Quarterly, 30*(2), 159-184.

Reich, W. (1969). *The sexual revolution: Toward a self-governing character structure.* New York: Farrar, Straus and Giroux.

Reiss, A. (1967). Sex offenses: The marginal status of the adolescent. In J. Gagnon, & W.Simon (Eds.), *Sexual Deviance*. (pp. 43-61). New York: Harper & Row.

Reuben, D. (1969). *Everything you always wanted to know about sex, but were afraid to ask*. New York: Bantam Books.

Revitch, E., & Weiss, R.G. (1962). The pedophiliac offender. *Diseases of the Nervous System, 23,* 73-78.

Robinson, P. (1976). *The modernization of sex.* New York: Cornell University Press.

Robitscher, J. (1980). *The powers of psychiatry.* Boston: Houghton-Mifflin

Rosenberg, J. (1989). *Fuel on the fire: An inquiry into pornography and sexual aggression in a free society.* Vermont: The Safer Society Press.

Rosenhan, D.L. (1975). On being sane in insane places. In T.J. Scheff (Ed.), *Labeling madness* (pp. 54-72). New Jersey: Prentice-Hall, Inc.

Roundy, L. M., & Horton, A. L. (1990). Professional and treatment issues for clinicians who intervene with incest perpetrators. In A. L. Horton, B. L. Johnson, L. M. Roundy, & D. Williams (Eds.), *The incest perpetrator: A family member no one wants to treat* (pp. 164-189). Newbury Park: Sage Publications.

Roys, D. T. (1997). Empirical and theoretical considerations of empathy in sex offenders. I*nternational Journal of Offender Therapy and Comparative Criminology, 41*(1), 53-64.

Rubin, G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. In C. Vance (Eds*.), Pleasure and danger: Exploring female sexuality* (pp. 267-331). Boston: Routledge & Kegan Paul.

Ruggiero, K., McLeer, S., & Dixon, F. (2000). Sexual abuse characteristics associated with survivor psychopathology. *Child Abuse and Neglect 24*(7), 951-962.

Ruzek, J. (1993). Professionals coping with vicarious trauma. *NCP Clinical Newsletter, 3*(2), 17-21.

Salter, A. C. (1988). *Treating child sex offenders and victims: A practical guide*. New York: Sage Publications.

Salter, A.C. (2003). *Predators: Pedophiles, rapists, and other sex offenders.* New York: Perseus Books Group.

Scheff, T.J. (1975). On reason and insanity: Some political implications of psychiatric thought. In T.J. Scheff (Ed.), *Labeling madness*. (Pp. 12-20). New Jersey: Prentice-Hall, Inc.

Scheff, T.J. (1984). *Being mentally ill: A sociological theory.* New York: Aldine Publishing Company.

Scott E. (1989). Is there a criminal mind? *International Journal of Offender Therapy and Comparative Criminology, 33*(3), 215-226.

Serrano, A. C., & Gunzburger, D. W. (1983). An historical perspective on incest. *International Journal of Family Therapy*, *5*(2), 70-80.

Shattuck, R. (1996). *Forbidden knowledge: From Prometheus to pornography*. New York: St. Martin's Press.

Shay, J. (1996). No escape from philosophy in trauma treatment. In B. Hudnell Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers & educators.* New York: The Sidran Press.

Shearer, S. L., & Herbert, C. A. (1987). Long-Term effects of unresolved sexual trauma. *American Family Physician, Oct.,*169-175.

Shelby, R.A. (2001). Factors contributing to levels of burnout among sex offender treatment providers. *Journal of Interpersonal Violence, 16*(11), 1205-1217.

Soothill, K.L. (1980). Incest: changing patterns of social response. In W.H.G. Armytage, R. Chester, & J. Peel (Eds.), *Changing patterns of sexual behavior: Proceedings of the 15th annual symposium of the eugenics society, London* (pp. 171-193). London: Academic Press.

Spindler, G., & Spindler, L. (1987). *Interpretive ethnography of education at home and abroad.* New Jersey: Lawrence Erlbaum Assoc. Inc.

Stamm, B.H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly, 8*(2), 1-8.

Steed, L.G., & Downing, R. (1998). A phenomenological study of vicarious traumatization amongst psychologists and professional counselors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies, 1998-2*. Retrieved April 19, 2005, from http://www.massey.ac.nz/~trauma/

Steed, L., & Bicknell, J. (2001). Trauma and the therapist: The experience of therapists working with the perpetrators of sexual abuse. *The Australasian Journal of Disaster and Trauma Studies*, Retrieved October 4, 2005 from http://www.massey.ac.nz/~trauma/issues/2001-1/steed.htm

Steele, B.F., & Alexander, H. (1981). Long term effects of sexual abuse in Childhood. In P. Mrazek, & C. H. Kempe (Eds.), *Sexually abused children and their families*. Oxford: Pergamon Press.

Stolorow, R.D., & Atwood, G.E. (1992). *Contexts of being: The intersubjective foundations of psychological life.* Hillsdale New Jersey: Analytic Press.

Storr, A. (1964). *Sexual deviation*. Baltimore, Maryland: Penguin Books. Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park: Sage Publications.

Strauss, A., & Corbin, J. (1990). Basics *of qualitative research: Grounded theory, procedures and techniques.* Newbury Park: Sage Publications.

Sullivan, P.J. (1993). Occupational stress in psychiatric nursing. *Journal of Advanced Nursing, 18,* 591-601.

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct.* New York: Harper & Row.

Szasz, T. (1983). Talking about sex: Sexual pathology and therapy as rhetoric. In C. M. Davis (Ed.), *Challenges in sexual science: Current theoretical issues and research advances* (pp. 1-7). Syracuse,New York: Society for the Study of Sex.

Szasz, T. (2002). Sins of the fathers: Is child molestation a sickness or a crime. *Reasonline.* Retrieved February 23, 2003, from http://reason.com/0208/fe.ts.sins.shtml

Travis, J., & Titus, R. (1996). *Victim costs and consequences: A new look* (Report No. NCJ 155282) National Institute of Justice.

Trippany, R.L., White-Kress, V.E., & Wilcoxen, S.A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82*(1). Retrieved January 4, 2006, from http://weblinks2.epnet.com/citation

Twitchell, J. B. (1987). *Forbidden partners: The incest taboo in modern culture*. New York: Columbia University Press.

Valliant, P. M., & Antonowicz, D. H. (1992). Rapists, incest offenders, and child molesters in treatment: Cognitive and social skills training. *International Journal of Offender Therapy and Comparative Criminology, 36*(3), 221-231.

Vanderbilt, H. (1992). Incest: A chilling report. *Lears Magazine* February, 44-72.

Violanti, J.M., & Aron, F. (1993). Sources of police stressors, job attitudes, and psychological distress. *Psychological Reports, 72*(3), 899-904.

Vogt, W.P. (1999). *Dictionary of statistics and methodology: A non-technical guide for the social sciences.* Thousand Oaks, California: Sage Publications.

Wagner, D., Heinrichs, M., & Ehlert, U. (1998). Prevalence of symptoms of post-traumatic stress disorder in German professional fire-fighters. *American Journal of Psychiatry, 155*(12), 1727-1732.

Ward, T., Hudson, S., & Keenan, T. (2000). The assessment and treatment of sexual offenders against children. In C.R. Hollin (Ed.), *Handbook of offender assessment and treatment* (pp. 351-361), New York: John Wiley & Sons Ltd.

Ward, T., Hudson, S., & Marshall, W. L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist impression. *Sexual Abuse: A Journal of Research and Treatment, 7*(1), 67-83.

Way, I., VanDeusen, K.M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19*(1), 49-71.

Wee, D., & Myers, D. (2002). Response of mental health workers following disaster: The

Oklahoma City bombing. In C.R. Figley (Ed.), *Treating compassion fatigue.* New York: Brunner/Rutledge.

Weeks, J. (1981). *Sex, politics, and society: The regulation of sexuality since 1800.* London: Longman.

Weiderholt, I.C. (1992). The psychodynamics of sex offenses and implications for treatment. In E. Coleman, S.E. Dwyer, and N.J. Pallone (Eds.), *Sex offender treatment: Psychological and medical approaches*. (Pps. 19-24). New York: Haworth Press, Inc.

Weiss, D.S., & Marmar, C.R. (1995). The Impact of Events Scale-Revised. In J.P. Wilson and T.M. Keane (Eds.), *Assessing psychological trauma and PTSD: A practitioners handbook.* New York: Guilford.

Wilson, & Keane, (1997). *Assessing psychological trauma and PTSD.* New York: Guilford Press.

Wilson, J.P., & Lindy, J.D. (1994). *Countertransference in the treatment of PTSD.* New York: Guilford Press.

Yalom, I.D. (1995). *The theory and practice of group psychotherapy.* New York: Perseus Books Group.

Yochelson, S., & Samenow, S. (1986). *The criminal personality, volume II; The change process.* Northvale, New Jersey: Jason Aronson.

Zuskin, R.E. (1992). Developing insight in incestuous fathers. In E. Coleman, S.E. Dwyer, and N.J. Pallone (Eds.), *Sex offender treatment: Psychological and medical approaches,* (Pps. 205-216). New York: Haworth Press, Inc.

APPENDICES

Appendix A

Informed Consent Form

Clinicians' Descriptions of Their Experience as Sex Offender Therapists

Explanation:

You are being asked to participate in a research interview designed for the purpose of understanding the experiences of sex offender treatment therapists. Specifically, you will be asked to detail your thoughts, feelings and experiences about the client/ therapist relationship in your work with sex offenders. As an experienced professional in the field, your perspectives and insights are highly valued.

If you decide to participate you will be asked a series of questions which will require approximately one to two hours of your time.

Participation:

Your participation is completely voluntary. There is no penalty for refusal to participate, and you are free to withdraw your consent and participation at any time. You are also free to decline to answer any questions that make you uncomfortable. If you wish to end the interview or to decline answering a question at any time, please tell the interviewer. ***As an added assurance that your description of your work is represented accurately, the researcher may need to contact you after transcribing your interview for additional input.***

If you experience any emotional discomfort as a result of the interview process, you may contact Ken Bond by phone at (405) 707-9458 or by E-mail at knrbond@sbcglobal.net, or Dr. Al Carlozzi by phone at (405) 744-7099 or by E-mail at alcar@okstate.edu for assistance. If you have any questions or concerns about this research project you may contact Dr. Carol Olson, IRB Chair at the Oklahoma State University Internal Review Board at (405) 744-5700.

Anonymity and Confidentiality:

The information you provide may be made available for public consumption. However, your name and any identifying information will be kept confidential. No one will be able to connect your name or any other type of personal information with the information you provide during the interview. With your permission, this interview will be audio taped. Audio tapes will be stored in a secure location until one year after the end of this project. At that time, all audio tapes will be erased.

____ **I agree to be audio taped.**

____ **I do not wish to be audio taped.**

Informed Consent:

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Name: _____ (please print clearly)

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Appendix B

Oklahoma State University
Institutional Review Board

Date: Monday, April 26, 2004 IRB Application No ED04107

Proposal Title: Clinicians' Descriptions of Their Experiences as Sex Offender Therapists

Principal Investigator(s):

Ken Bond
2523 North Monroe
Stillwater, OK 74075

Al Carlozzi
202 Whitehurst
Stillwater, OK 74078

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s) : Pending Revision

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There are revisions to your application to the IRB, which must be completed satisfactorily before your protocol will be approved. They are listed on the following page.

Please submit a revised IRB application incorporating and HIGHLIGHTING the changes listed. You may address very minor revisions in a memo. If any changes are requried to your consent form, you must submit a new consent form incorporating the changes.

This material containing your revisions should be returned to the IRB Office, 415 Whitehurst Hall, Stillwater, OK 74078. These revisions will be reviewed by the IRB Chair and/or the review committee of the IRB. When all outstanding issues have been addressed satisfactorily, you will receive an approval letter from the Chair of the IRB.

You may not begin this research until these revisions have been made and the IRB has granted final approval to conduct research using human subjects under this protocol. You will be allowed 60 days to respond satisfactorily to the revisions required by the IRB. After that period of time, your protocol will be CLOSED.

If you have questions or wish to discuss the reviewers' comments, please contact me at 405-744-5700 or via e-mail at colson@okstate.edu.

Oklahoma State University
Institutional Review Board
Reviewer Comments

Date : Monday, April 26, 2004 IRB Application No ED04107

Proposal Title: Clinicians' Descriptions of Their Experiences as Sex Offender Therapists

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The investigator mentions a follow up of some of the subjects both in the application and in the research plan. However, this possibility is not mentioned in the consent form and it needs to be.

Signature

Carol Olson, Director of University Research Compliance

Monday, April 26, 2004
Date

Appendix C

Oklahoma State University Institutional Review Board

Date:	Friday, November 18, 2005
IRB Application No	ED0654
Proposal Title:	Clinicians' Descriptions of Their Experience as Sex Offender Therapists
Reviewed and Processed as:	Exempt

Status Recommended by Reviewer(s): Approved Protocol Expires: 11/17/2006

Principal Investigator(s

Ken Bond
2523 North Monroe
Stillwater, OK 74075

Al Carlozzi
434 Willard
Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☒ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 415 Whitehurst (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Sue C Jacobs

Sue C. Jacobs, Chair
Institutional Review Board

Appendix D

Interview Guide #1

1. How did you choose to become a sex offender therapist?
2. How long have you worked as a sex offender therapist?
3. How did you initially decide to become a sex offender therapist?
4. What in your life or training influences your choices as a sex offender therapist (initial and continuing choices)?
5. Describe your work as a sex offender therapist?
6. Upon what theory do you base your approach to sex offender treatment?
7. What effect has working as a sex offender therapist had on you?
8. When people ask you why you work with sex offenders, what do you reply?
9. Why do sex offender therapists treat sex offenders?
10. What have you learned about yourself in working with sex offenders?
11. What motivates you to continue working as a sex offender therapist?
12. What are the qualities necessary to be a good sex offender therapist?
13. Do you have any additional comments you would like to make?

Appendix E

Interview Guide #2

1. How did you choose to become a sex offender therapist?
2. Describe the training that prepared you to become a sex offender therapist.
3. Describe your work as a sex offender therapist.
4. What issues in working with sex offenders do you find the most difficult for you personally?
5. How do you manage your personal reactions to sex offender issues?
6. How are you able to maintain a therapeutic alliance with sex offenders, or are you?
7. When people ask you why you work with sex offenders, what do you reply?
8. Why do sex offender therapists treat sex offenders?
9. What have you learned about yourself in working with sex offenders?
10. What motivates you to continue working as a sex offender therapist?
11. Do you have any additional comments you would like to make?

VITA

Ken Bond

Candidate for the Degree of

Doctor of Philosophy

Thesis: CLINICIANS' DESCRIPTIONS OF THEIR EXPERIENCES AS SEX OFFENDER THERAPISTS

Biographical:

Personal Data: Born 1962, Oklahoma City, Oklahoma

Education: Oklahoma State University Doctoral Student in APA-Accredited Counseling Psychology Program	2000-2006
University of Oklahoma-Norman, Oklahoma	1989-1994
Teaching Certification (Language Arts-Secondary)	1994
M.Ed. Community Counseling	1993
B.A. Psychology	1991

Completed the Requirements for the Doctor of Philosophy Degree at Oklahoma State University in May, 2006.

Experience: Stillwater Domestic Violence Services, Inc.	2001-2006
Oklahoma State Department of Corrections	1997-2000
Spark Matsunaga Veterans Administration Medical Center Honolulu, Hawaii	2004-2005

Professional Memberships: Licensed Professional Counselor- Oklahoma
Teaching Certification- Oklahoma
American Psychological Association

Name: Ken Bond Date of Degree: May, 2006

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: CLINICIANS' DESCRIPTIONS OF THEIR EXPERIENCES AS SEX OFFENDER THERAPISTS

Pages in Study: 177 Candidate for the Degree of Doctor of Philosophy

Major Field: Educational Psychology

Scope and Method of Study: The purpose of this study is to explore the experience of sex offender therapists. It is to have them tell what is going on. This study is about how being a therapist that works with sex offenders is an unusual undertaking. The nature of treatment for sex offenders is very different from that found in a more typical client/therapist relationship. Twelve sex offender therapists were interviewed and asked to describe what they think about sex offenders, what it is like to work as a sex offender therapist, what affects does the work have on them and how do they manage those affects.

Findings and Conclusions: The participants in this study discussed how they attempt to understand sex offenders and the nature of sexual deviancy. They described how they attempt to use that understanding in their work with sex offenders. They described difficulties they experience attempting to relate to other people who they see as non-supportive of their work. They also gave extensive descriptions of how recurrent exposure to the traumatic content related to sexual assaults has a negative impact on them personally. Those negative effects were consistent with the concept of vicarious traumatization. The therapists' descriptions were discussed in terms of the symptoms of PTSD which are proposed as consistent on sub-clinical levels with vicarious traumatization. The sex offender therapists also discussed the measures they employ to alleviate the effects of vicarious traumatization. The most important of these measures was accessing the personal support of other sex offender therapists.

ADVISOR'S APPROVAL: Dr. Alfred Carlozzi